

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a film 402 Maryland State Department of Health
1-18-68 mt 05697
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05709

1. DECEASED-NAME (Type or Print)		First AVERY	Middle NEWTON	Last AYRES, III	2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 4/30/68 19		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH Jan. 6, 1952		6. AGE (In years last birthday) 16 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year April 30, 1968
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route #3		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Route #3, B-47		13f. STREET AND NUMBER Wright's Trailer Village					
14. FATHER'S NAME First Middle Last Avery Newton Ayers Jr.		15. MOTHER'S MAIDEN NAME First Middle Last Lucille Simmons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Father, Same as 10-&11			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause of death undetermined at autopsy 7969 DUE TO, OR AS A CONSEQUENCE OF and by Chemical analyses. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7955							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 4/30/68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2 May 68		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Aberdeen, Harford- Md.	
24. FUNERAL DIRECTOR Webster W. W. W. L.				Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE MAY 3 1968	
25b. REGISTRAR'S SIGNATURE J. Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30A REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <i>Anne Elizabeth Battista</i>			2a. DATE OF DEATH Month Day Year <i>April 1 1968</i>			2b. HOUR <i>1:26</i> M			
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>June 14, 1915</i>		6. AGE (In years last birthday) <i>52</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Bridgeport, Conn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.			
10. CITY OR TOWN OF DEATH <i>HARFORD</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Pharmaceutical</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>Joppa</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2617 Green Spring Ave</i>	
14. FATHER'S NAME First Middle Last <i>Unknown</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>040-09-8899</i>		17. INFORMANT Address <i>Joppa, Md.</i> <i>Frank J. Battista, 2617 Green Spring Ave.,</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>410.9 Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.C.V. D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> , 19 <i>68</i> , to <i>Mar 31</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Mar 31</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John D. Yuen</i>		DEGREE <i>MD.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/1/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>JOHN D. YUEN</i>		22e. ADDRESS <i>HAURE DE GRACE MD</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Apr. 4, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Bel Air Harford Md</i>			
24. FUNERAL DIRECTOR <i>Howard K. McConas & Son, Abingdon, Md.</i>				ADDRESS <i>Abingdon, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>	



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street		c. LENGTH OF STAY IN 1b 7 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last BAY		4. DATE OF DEATH Month April Day 1 Year 1968	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1895
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (County & State, or foreign country) Whiteford, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel W. Bay		14. MOTHER'S MAIDEN NAME Mary A. Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-36-8275	
17. INFORMANT Mrs. John W. Bay, Street, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary sclerosis DUE TO (c) Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201 Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1940 to April 1, 1968 , that (I) (we) last saw the deceased alive on March 3, 1968 , and that death occurred at 11:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Josiah A. Hunt		22b. DATE SIGNED Apr. 3, 1968	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt		22d. ADDRESS Delta, Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 4, 1968	
23c. NAME OF CEMETERY OR CREMATORY Highland		23d. LOCATION (City or Town) (County) (State) Street, Harford, Md.	
24. FUNERAL DIRECTOR John H. Harkins		25a. REC'D BY REGISTRAR APR 5 - 1968	
ADDRESS Delta, Penna.		25b. REGISTRAR'S SIGNATURE Charles Judge	

0750

0830

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VR 410
304 REV. 4/68

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARY Clyde Bebbler		2a. DATE OF DEATH April 15 68		2b. HOUR 12 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH December 23, 1912	6. AGE (In years last birthday) 55	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARford Co.		
10. CITY OR TOWN OF DEATH Harford GRACE	11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) HARford	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 11 Elm Street	
14. FATHER'S NAME First LEE Middle A. Last COMER	15. MOTHER'S MAIDEN NAME First DOANA Middle BIEVINS Last BIEVINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO	(If yes give war or dates of service) —	16b. SOCIAL SECURITY NO. 218-26-3878	17. INFORMANT Husband (838-2704) Address 11 Elm Street Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARIAL THROMBOSIS 4129 DUE TO, OR AS A CONSEQUENCE OF (b) AURICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS. WEEKS YEARS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) 4830					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/4 , 19 68 , to 4/14 , 19 68 , that (I) (we) last saw the deceased alive on 4/14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles Judge	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4-15-68
22d. PHYSICIAN'S NAME (Type) S. LEYTE-VIGAL	22e. ADDRESS 114 W. BEL AIR AVE. ABERDEEN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 17, 1968	23c. NAME OF CEMETERY OR CREMATORY Welcome Home Baptist Ch. Cem.	23d. LOCATION (City or Town) Bel Air	(County) Harford Co.	(State) Maryland
24. FUNERAL DIRECTOR Joseph William Foster	ADDRESS W. Broadway & Williams St. BEL Air, Maryland 21014		25a. REC'D BY REGISTRAR APR 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

05703

1. The first part of the report deals with the general conditions of the country during the year 1930. It is found that the weather was generally favorable for the crops, but that the drought in the West was still a serious problem. The crops were generally good, but the yield was not as high as in previous years. The stock raising industry was also affected by the drought, and the price of stock was low. The government has taken steps to help the farmers, but more is needed. The second part of the report deals with the specific crops. It is found that the wheat crop was good, but the yield was not as high as in previous years. The corn crop was also good, but the yield was not as high as in previous years. The cotton crop was good, but the yield was not as high as in previous years. The sugar crop was good, but the yield was not as high as in previous years. The other crops were also good, but the yield was not as high as in previous years. The third part of the report deals with the stock raising industry. It is found that the price of stock was low, and the government has taken steps to help the farmers. The fourth part of the report deals with the government's policy. It is found that the government has taken steps to help the farmers, but more is needed. The fifth part of the report deals with the future. It is found that the future is uncertain, but the government has taken steps to help the farmers.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Harvey Wilson Benjamin			2a. DATE OF DEATH Month 4 Day 5 Year 1968			2b. HOUR 4:30 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug 14 - 1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Three-de-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt #2	
14. FATHER'S NAME First William W Middle Benjamin Last Josephine			15. MOTHER'S MAIDEN NAME First Wilson Middle Josephine Last Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. 187-054673		17. INFORMANT Henry Benjamin Rising Sun Md. Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4120 DUE TO, OR AS A CONSEQUENCE OF (b) ASCD + Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wk		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 442x Fracture hip									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-26 , 19 48 , to 4-5 , 19 48 , that (I) (we) last saw the deceased alive on 4-3 , 19 48 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Chs J. Grigoleit MD				DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/5/68			
22d. PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT				22e. ADDRESS Harrods Grace					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-9-68		23c. NAME OF CEMETERY OR CREMATORY Bay View Cem.		23d. LOCATION (City or Town) (County) (State) Bay View Cecil Md.			
24. FUNERAL DIRECTOR Richard L Goodie				ADDRESS Rising Sun Md		25a. REC'D BY REGISTRAR APR 9 - 1968		25b. REGISTRAR'S SIGNATURE Richard L Goodie	

DATE

STATE OF TEXAS

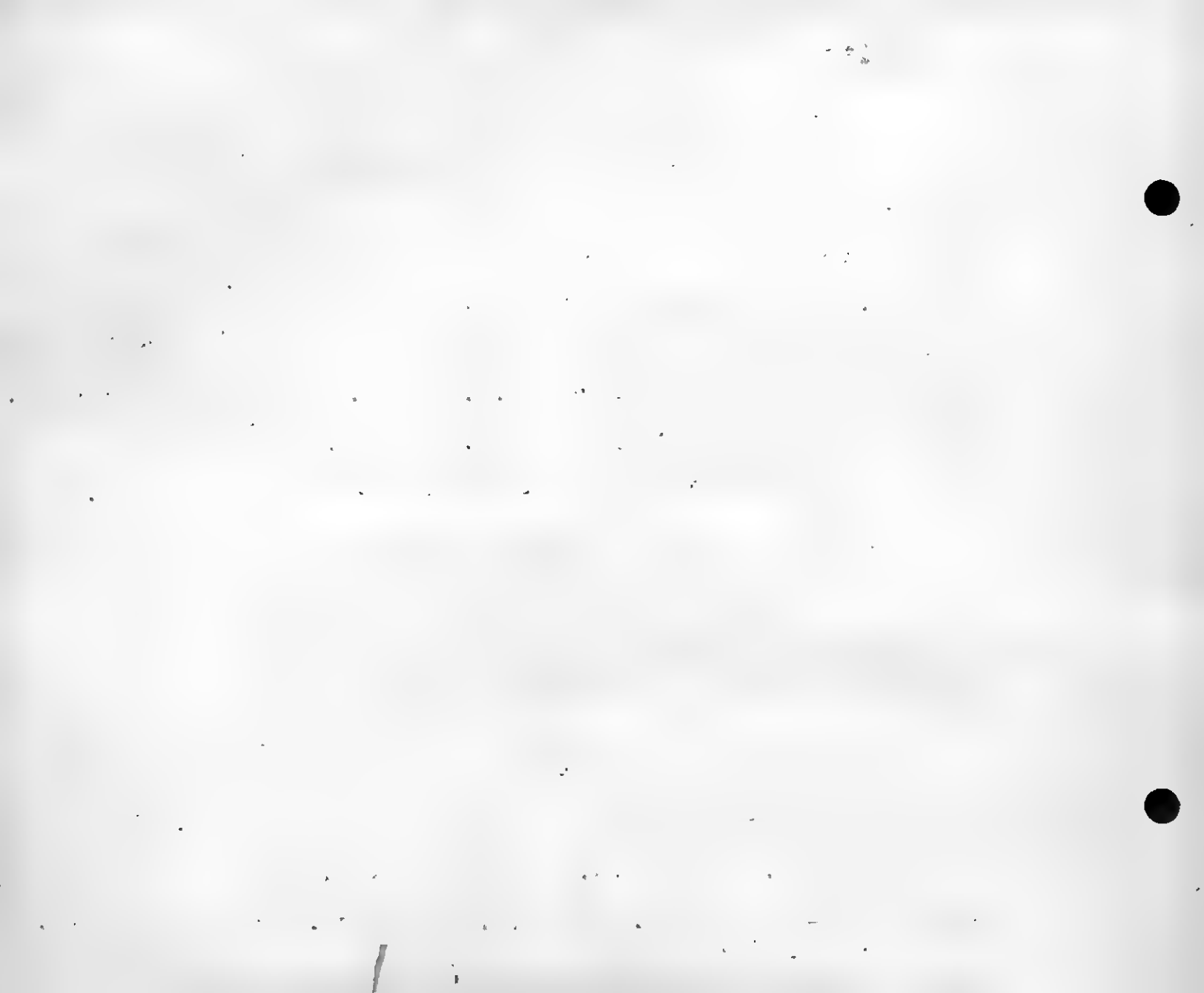
10759

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Leo Middle Jack Last Bonin			2a. DATE OF DEATH Month April Day 23 Year 68			2b. HOUR 3:30A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 31, 1895		6. AGE (In years lost birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) France		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Chicken Farmer		12b. KIND OF BUSINESS OR INDUSTRY Self Employ	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Route 274							
14. FATHER'S NAME First Peter Middle Bonin Last Bonin			15. MOTHER'S MAIDEN NAME First Mary Middle Bonin Last Bonin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 221-09-5770		17. INFORMANT Address Mrs. Leo. J. Bonin Rising Sun, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 2 v.s.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6-6 , 19 67 , to 4-23 , 19 68 , that (I) (we) last saw the deceased alive on 4-22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Neil R. Taylor DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4-25-68			
22d. PHYSICIAN'S NAME (Type) Neil R. Taylor MD.				22e. ADDRESS Rising Sun, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-1968		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cem.		23d. LOCATION (City or Town) (County) (State) Rising Sun Cecil Md.	
24. FUNERAL DIRECTOR Erning McMillen				25a. REC'D BY REGISTRAR Rising Sun, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Annie LEE Castell							Month	Day	Year	9 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
F		Wh		1-5-1880			88 YRS.		MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.		U.S.A.				Harford.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace			Citizens Nursing Home			Homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP		13e. STREET AND NUMBER	
Md.				Harford		Bel Air, Md.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		704 Hickory Ave Bel Air, Md.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Charles Edward Ely				Sarah Elizabeth Forward							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT (Sister) 838-6830 Address 704 Hickory Avenue Bel Air, Maryland 21014					
				220-44-3326		Mrs. Lulu B. Boyle					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis										3-4 months	
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerotic Cardio-											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) Vascular Disease										2-3 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Insanity											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 1st, 1967, to April 29, 1968, that (I) (we) last saw the deceased alive on April 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
Edward C. Lee, M.D.								4/29/68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
Edward C. Lee, M.D.				Havre de Grace, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		May 2, 1968		Mt. Zion Meth. Ch. Cem.		Bel Air, Harford Co., Md. 21014					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph William Foster				W. Broadway & Williams St. Bel Air, Maryland 21014		DATE MAY 11 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

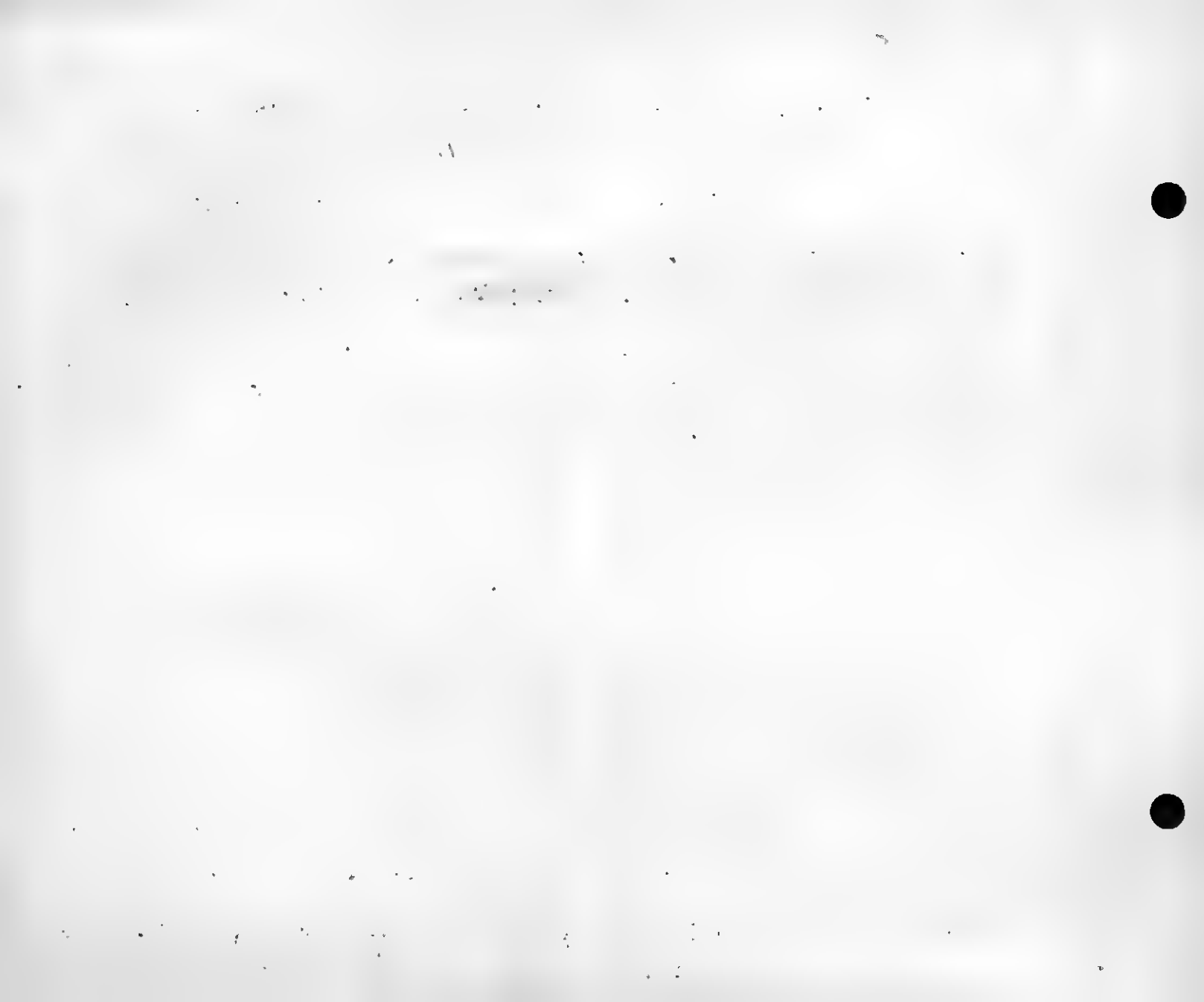
1 DECEASED-NAME (Type or print) First Middle Last ELMER (NMN) COMBS			2a. DATE OF DEATH 4 Month 14 Day 68 Year		2b. HOUR 4:40 PM
3. SEX Male	4. RACE Caucasian		5. DATE OF BIRTH 7/20/15		6. AGE (In years last birthday) 52 YRS
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md
10. CITY OR TOWN OF DEATH HARRE de GRACE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HARFORD MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER	
12b. KIND OF BUSINESS OR INDUSTRY St. Rd. Comm.		13a. USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY HARFORD	13c. CITY OR TOWN Bel Air
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD 2 Box 98-A			
14. FATHER'S NAME First Middle Last Jacob (NMN) COMBS			15. MOTHER'S MAIDEN NAME First Middle Last ROSA — CROUSE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 238-10-9162		17. INFORMANT (NAME) (RELATIONSHIP) (ADDRESS) Mrs. JEAN B. Combs 2nd 2, Box #98-A Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 4367 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Asthma & Emphysema</u>					
19a. DATE OF OPERATION 4/10/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pyloric stenosis (ulcer)		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> refused	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9/68</u> , 19 <u>68</u> , to <u>4/14/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/14/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Owl Grigoleit MD		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/14/68	
22d. PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT		22e. ADDRESS Harre de Grace, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Maryland 21014					
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. RECD BY REGISTRAR DATE APR 17 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Thomas			Gordon	Coulter	April 21 1968			40 M	
3 SEX	M	4. RACE	W	5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. AGE (In years lost birthday)	
6-18-93		74 YRS		IF UNDER 1 YEAR		IF UNDER 24 MRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S. A.				Hartford Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace			Citizens Nursing Home			R. Engineer (ret'd.)			railroad
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.			Hartford			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
								2106 Railroad Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Morris			H.	Coulter		Anna V. Junce			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			717-07-6770			Mrs. Florence E. Schumaker, 2106 Railroad Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the liver.</u>									
100% DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Arteriosclerotic heart disease, CVD.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS.		22c. DATE SIGNED
<u>[Signature]</u>							<input checked="" type="checkbox"/>		April 21, 1968
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Lajos Mezei, M.D.					Havre de Grace, Maryland				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Apr. 24, 1968		Columbia Memorial Cemetery		Abingdon		Hartford	Md.
24. FUNERAL DIRECTOR					25a. REC'D BY		25b. REGISTRAR'S SIGNATURE		
Howard K. McCorns, Jr. Son, Abingdon, Md.					APR 24 1968		<u>[Signature]</u>		



CERTIFICATE OF DEATH

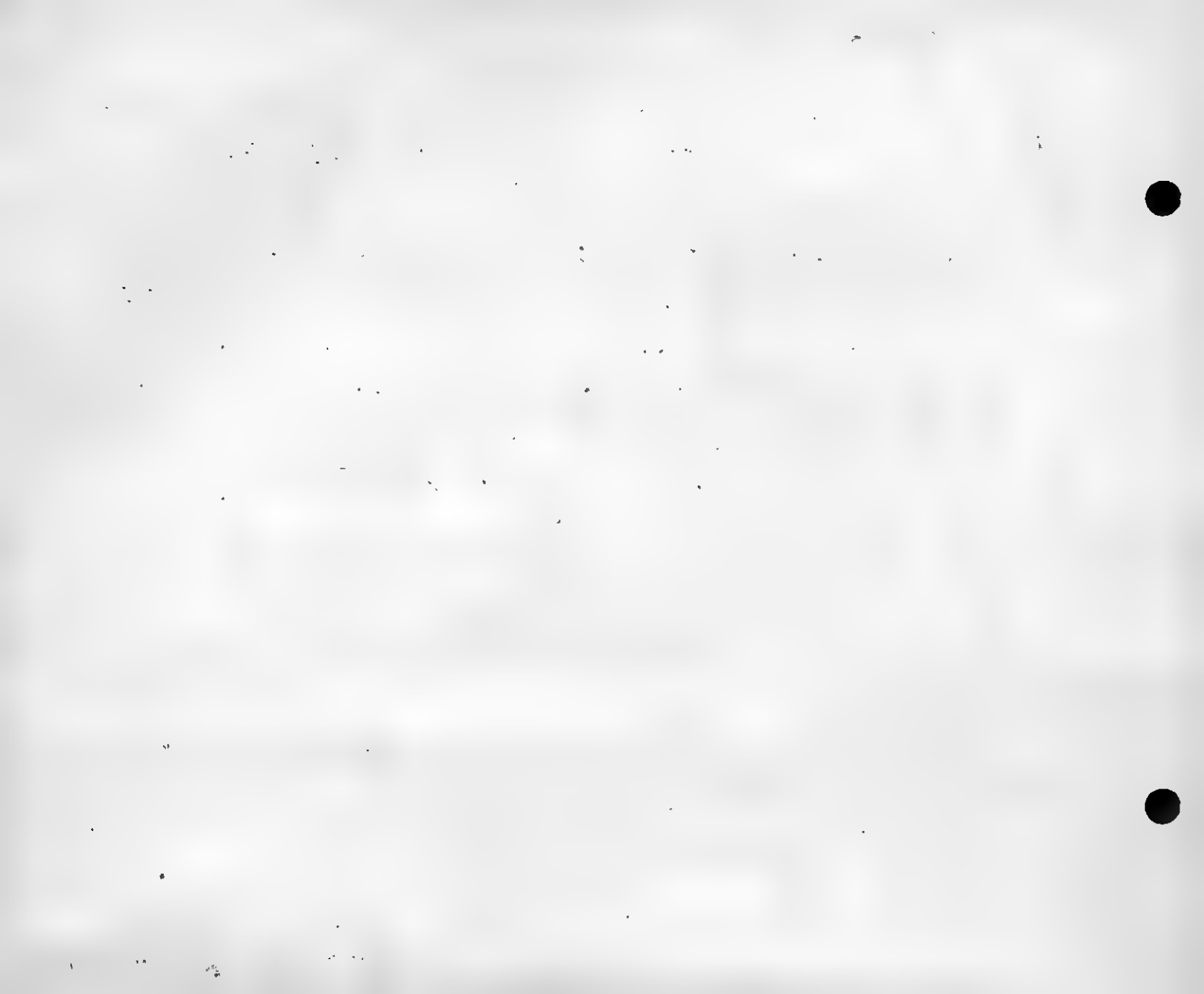
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Charles Grant Dawson			2a. DATE OF DEATH Month April Day 13 Year 1968			2b. HOUR 11A M	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH April 13, 1903		6. AGE (In years last birthday) 65 YRS	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAINTER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY HARFORD		13c. CITY OR TOWN DARLINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First GRANT Middle DAWSON Last DAWSON			15. MOTHER'S MAIDEN NAME First SARAH JANE Middle CARTER Last CARTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) No (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. 214-18-9515		17. INFORMANT Address MRS. C.G. DAWSON, DARLINGTON, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436.9 Cardiovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 249ns Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30-40 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) MI							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1947 , to April 13, 1968 , that (I) (we) lost saw the deceased alive on April 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dudley Phillips MD				22c. DATE SIGNED 4/13/68		22d. PHYSICIAN'S NAME (Type) Dudley Phillips MD	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE 4-15-68		23c. NAME OF CEMETERY OR CREMATORY ASCENSION		23d. LOCATION (City or Town) (County) (State) STREET, HARFORD, MD.	
24. FUNERAL DIRECTOR ADDRESS JOHN H. HARKINS, DELTA, PA.				25a. REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) WILLIS FRANK DINSMOOR			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 21 Year 1968			2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 5/4/1919	6. AGE (in years last birthday) 54 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 4 Day 21 Year 1968
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD
10. CITY OR TOWN OF DEATH HAVRE DE GRACE MD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) STOCK CLERK		12b. KIND OF BUSINESS OR INDUSTRY SHIP YARD
13a. USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE Md		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET AND NUMBER P.O. Box 42		14. FATHER'S NAME GLENN DINSMOOR		15. MOTHER'S MAIDEN NAME PEARL AGNES NICKERSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 071-10-5770		17. INFORMANT MARGARET S. DINSMOOR		ADDRESS PORT DEPOSIT MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt injuries of thorax DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION 4-24-1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 12:04 PM 4-20 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Involved in auto accident		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No City or Town County State Rt. 222 Perryville at Rte 275 Cecil Harford Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED April 22, 1968
23a. BURIAL (CREMATION, REMOVAL) (Specify) BURIAL		23b. DATE 4-24-1968		23c. NAME OF CEMETERY OR CREMATORY HOPEWELL CEM.		23d. LOCATION (City or Town) (County) (State) Cecil Co. MD.
24. FUNERAL DIRECTOR R. MADISON MITCHELL		ADDRESS MITCHELL, HAVRE DE GRACE MD		25a. RECEIVED BY REGISTRAR APR 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515 (1)
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Stanley EVANS Dixon			2a. DATE OF DEATH 4 Month 22 Day 68 Year		2b. HOUR 4:35 A. M.
3. SEX male	4. RACE white	5. DATE OF BIRTH 10-31-84		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Harvee de Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizen's Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MILK TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY Transport	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Jarrettsville	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER Norrisville Road	
14. FATHER'S NAME First Middle Last Benjamin Dixon		15. MOTHER'S MAIDEN NAME First Middle Last Emma Chenworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) ---	17. INFORMANT Mrs. Hazel D. Malles White Hall, Md. 21161			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V.D. (c) 2-3 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 1 week
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan. 16, 1968 to April 22, 1968 , that (I) (we) last saw the deceased alive on April 22, 1968 and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Leach	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/22/68		
22d. PHYSICIAN'S NAME (Type) Edward C. Leach, M.D.	22e. ADDRESS Harvee de Grace, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/24/1968	23c. NAME OF CEMETERY OR CREMATORY Jarrettsville	23d. LOCATION (City or Town) (County) (State) Jarrettsville, Maryland		
24. FUNERAL DIRECTOR Charles E. Kurtz	ADDRESS Jarrettsville, Md.		25a. REC'D BY REGISTRAR DATE APR 24 1968	25b. REGISTRAR'S SIGNATURE Charles Yunge	

21084



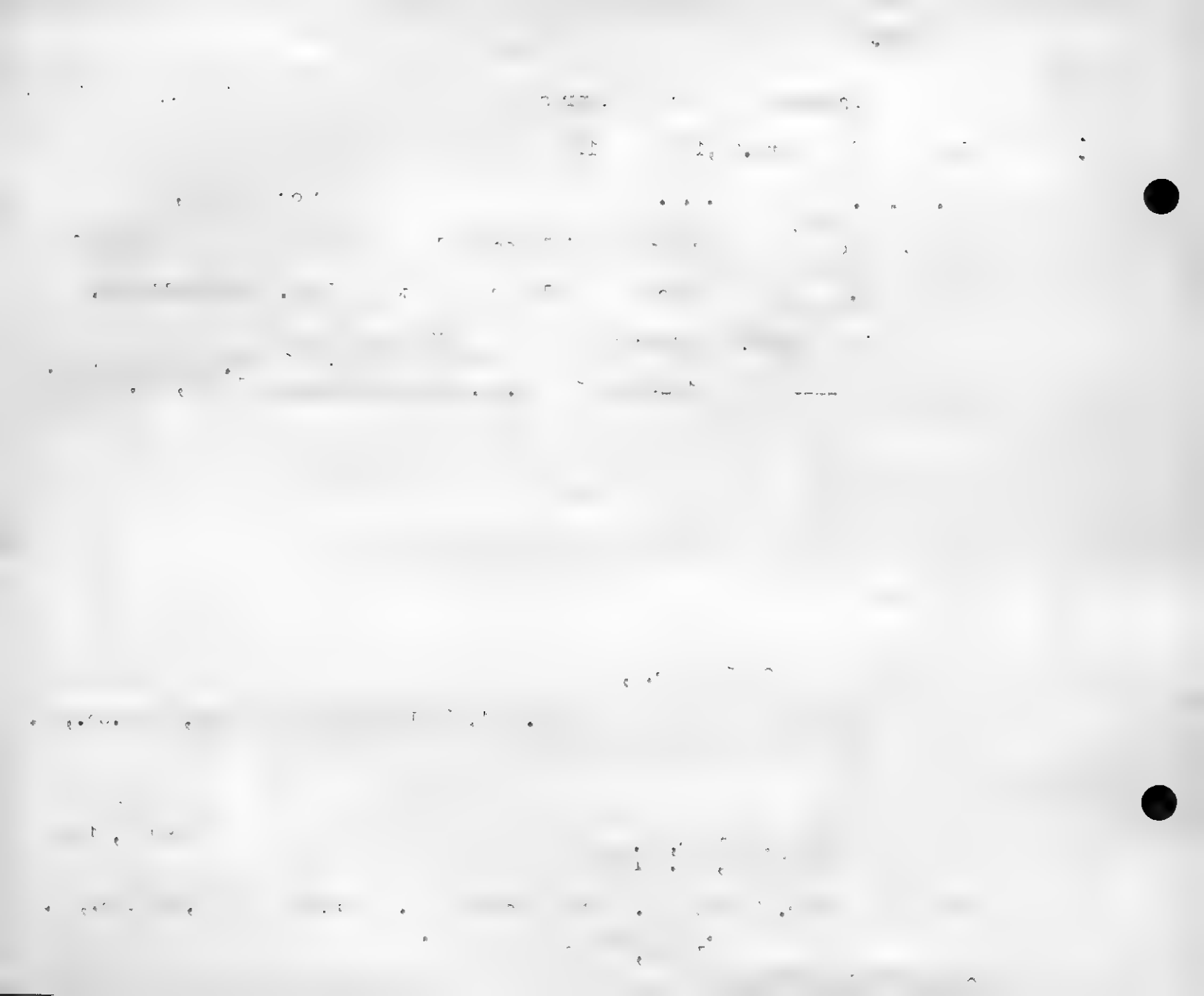
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Lawrence Reid Edwards						Month Day Year		4-9 1968 3:05 P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		
Male	White	Aug. 28, 1949	18 YRS					Month Day Year 4 9 1968 3:45 P.M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Harf. Co., Md.		U.S.A.				Harford County, Md				
10. CITY OR TOWN OF DEATH (DOA)			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace			Harford Memorial Hospital			Student		School		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Harford		Bel Air		YES		39 E. Churchville Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Reid Burnett Edwards			Mildred Virginia Spencer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) ----		17. INFORMANT (Father) 838-6063 39 E. Churchville Rd. Bel Air, Md. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull, open										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Fracture of femur							
			(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
X 157										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			3:05 P.M. Apr. 9, 1968		Auto Accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
				U.S.#1, 1 mile north of Bel Air, Harf. Co., Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Bel Air, Md.</i>				
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D. Bel Air, Md. 21014			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			April 9, 1968				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			Apr. 11, 1968		Mt. Zion Methodist Cem.		Fountain Green, Harf. Co., Md.			
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>			W. Broadway & Williams St. Bel Air, Maryland 21014			25a. RECD BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
Joseph William Foster										



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Ethel A. Glasgow			2a DATE KNOWN OF DEATH 4-8-68			2b HOUR 11:30		
3 SEX F	4 RACE W	5 DATE OF BIRTH DEC. 24, 1898	6 AGE 68 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	8 IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 4 Day 8 Year 1968		2d HOUR 11:30
7a BIRTHPLACE (State or foreign country) STREET, Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Hartford		
10 CITY OR TOWN OF DEATH Hartford		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Hartford Memorial Hosp. Inc.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b COUNTY Hartford		13c CITY OR TOWN STREET		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
13e STREET AND NUMBER GRIER NURSERY Rd.		14 FATHER'S NAME First GEORGE Middle AMOS Last AMOS		15 MOTHER'S MAIDEN NAME First MARGARET Middle LAIRD Last LAIRD		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16b SOCIAL SECURITY NO. 213-52-6305		17 INFORMANT CHARLES W. GLASGOW		ADDRESS STREET, Md.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
19a DATE OF OPERATION 6-20-68		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMATE OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 4-8-68 HOUR A.M. 11		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto Accident				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f LOCATION Street or R.F.D. No Street City or Town Hartford County Md. State Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Gerald E Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 4-8-68		
EXAMINER'S NAME (Type) Gerald E Palmer		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		23b DATE APRIL 11, 1968		23c NAME OF CEMETERY OR CREMATORY EMORY METHODIST		23d LOCATION (City or Town) (County) (State) STREET, HARTFORD, MD.		
24 FUNERAL DIRECTOR John H. Harding		ADDRESS DELTA, PA.		25a REC'D BY REGISTRAR APR 11 1968		25b REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

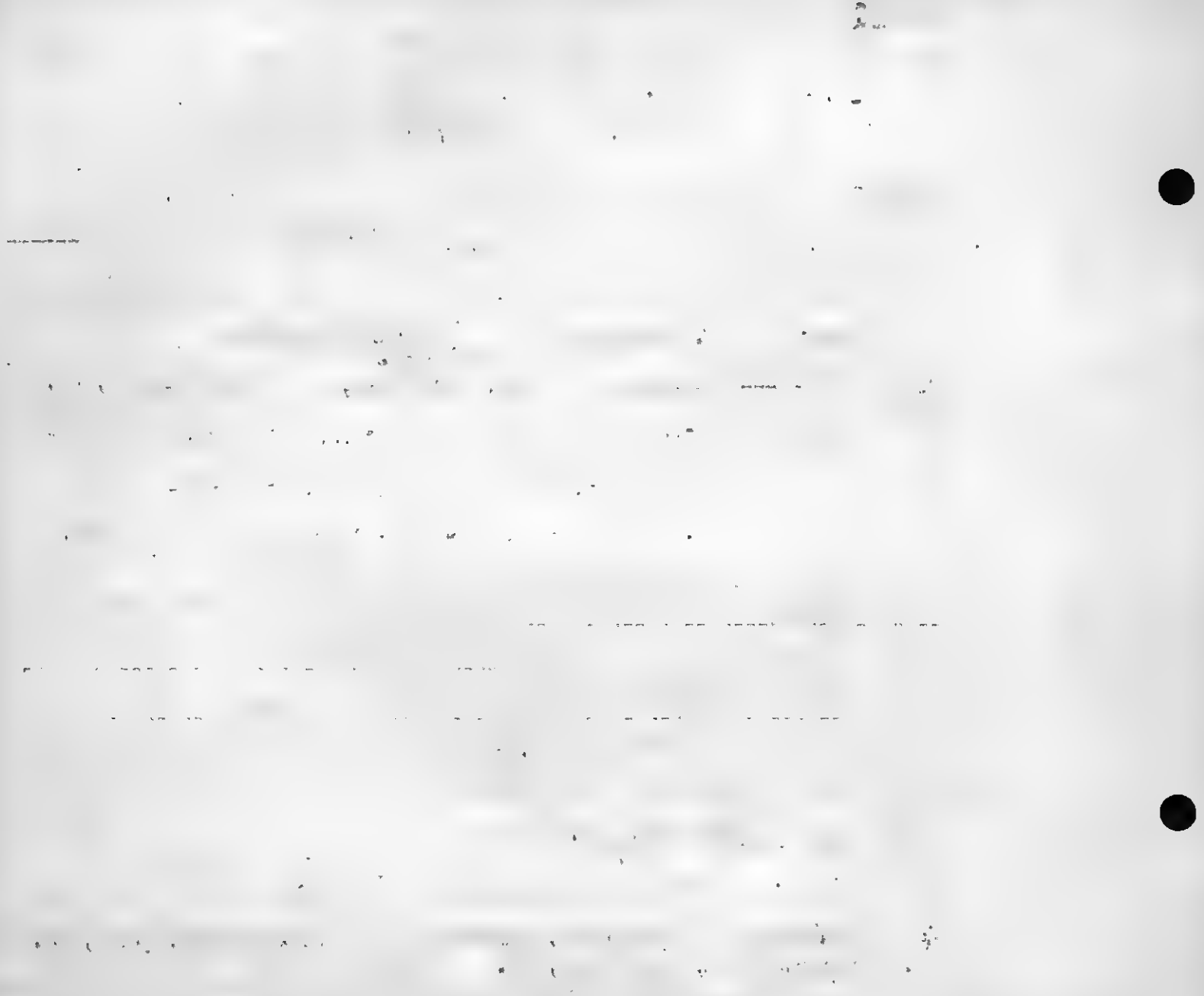


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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50712
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film G400 5/2/68 kk
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Clara E. Gumbey</u>			2a. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>68</u>			2b. HOUR <u>5:30</u> PM					
3. SEX <u>Female F</u>		4. RACE <u>C Colored</u>		5. DATE OF BIRTH <u>5/20/1968</u>		6. AGE (In years last birthday) <u>87</u> YRS.		7. IF UNDER 1 YEAR MONTHS _____ DAYS _____		8. IF UNDER 24 HRS HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Hartford</u> Md.					
10. CITY OR TOWN OF DEATH <u>Harre de Grace</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY _____		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>md</u>			13b. COUNTY <u>Cecil</u>			13c. CITY OR TOWN <u>Port Deposit</u>		13d. INSIDE CITY PM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>230 North Main St.</u>	
14. FATHER'S NAME First <u>George</u> Middle <u>W. Shortone</u> Last _____			15. MOTHER'S MAIDEN NAME First <u>Elizabeth Jane Rice</u> Middle _____ Last _____								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service) _____			16b. SOCIAL SECURITY NO. <u>Unknown</u>			17. INFORMANT <u>Mrs. Mae Newman</u>			Address <u>Port Deposit, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD With aneurysm aortic bifurcation with</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>occlusion right renal artery; further compli-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cated by chronic pyelonephritis and uremia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diverticulitis of lower colon</u>											
19a. DATE OF OPERATION <u>April 10, 1968</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) _____					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) _____ OFFICE, BUILDING, ETC. _____			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1968</u> , to <u>April 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George T. Stansbury, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>April 16, 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>George T. Stansbury, M. D.</u>						22e. ADDRESS <u>569 Revolution Street Harre de Grace, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/20/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jones Mem. Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Cecil, Md.</u>			
24. FUNERAL DIRECTOR <u>Lee H. Patterson & Son, Perryville, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 26 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



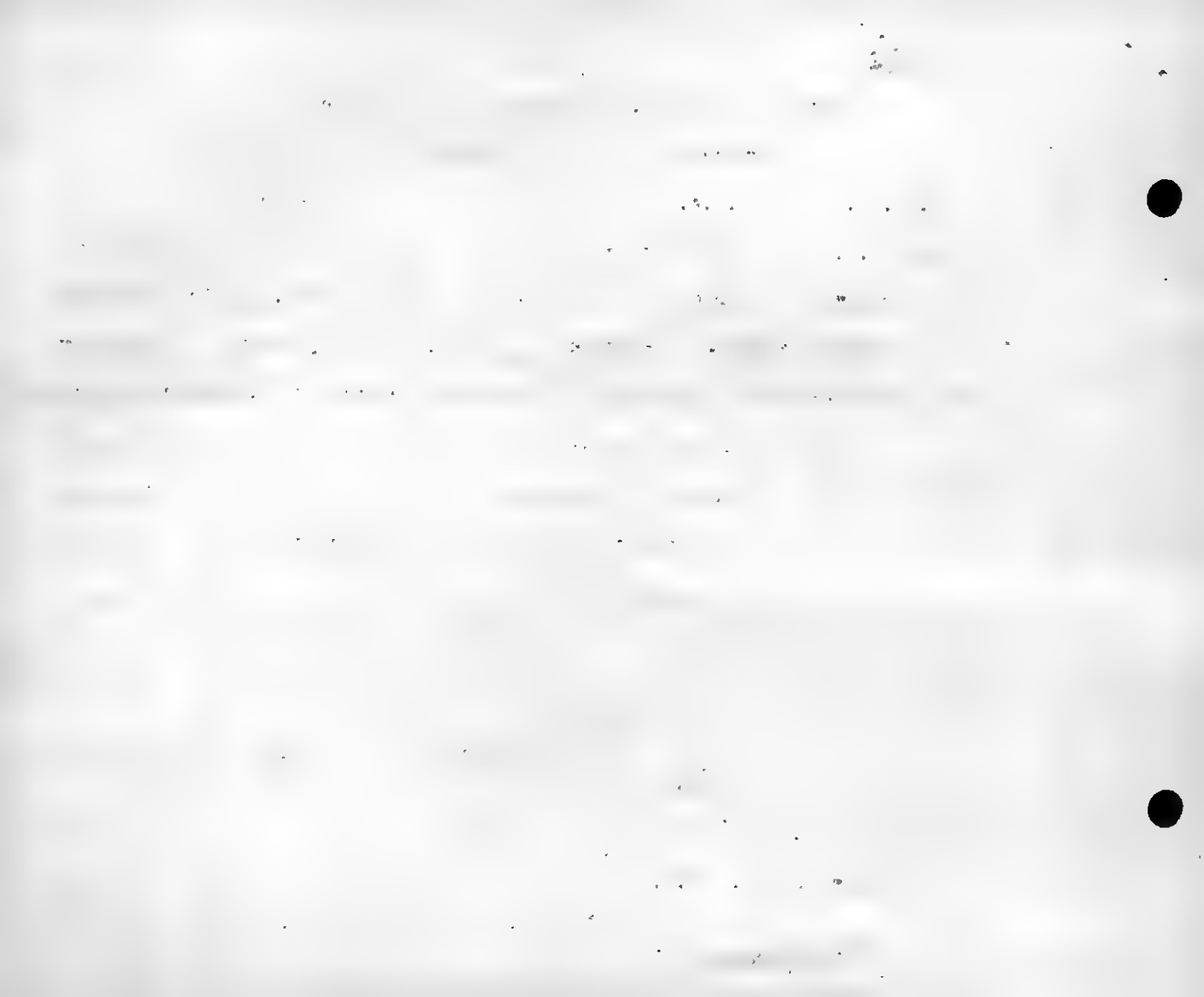
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
James		R.		Hamrick	April Month 7 Day 68 Year		0023 M	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male	Caucasian		5 March 1920		48 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
West Virginia		U.S.A.				Harford Md.		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Aberdeen P.G.		US Kirk Army Hospital		Army Ret		Army		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b CITY		13c CITY OR TOWN		13d INSIDE CITY LIM TSY		13e STREET AND NUMBER
Maryland		Harford		Aberdeen		YES <input type="checkbox"/> NO <input type="checkbox"/>		29 w. Belair Ave Box 702
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
James XXXXXX Hamrick		Marie NMI XXXXXX Cunningham						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT				
Yes 12 FEB 42 - 31 MAR 64		232-05-5303		Katharina Hamrick, 29 W. Belair Ave, Aberdeen				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>								2 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bleeding Peptic Ulcer</u>								13 days
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Possible perforation, hepatic cirrhosis CVA</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
		HOUR A.M. Month Day Year P.M. 19						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from <u>25 March</u> , 19 <u>68</u> , to <u>7 April</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7 April</u> , 19 <u>68</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (we) (do) (do not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED		
<i>Roger A. Nosal</i>						7 April 1968		
22d PHYSICIAN'S NAME (Type)		22e ADDRESS						
Roger A. Nosal, M.D.		US Kirk Army Hospital						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Removal		10 Apr. 68		East Oak Grove Cemetery		Morgantown, West Virginia		
24 FUNERAL DIRECTOR <i>Walter W. W. Jr.</i> ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Tarring Funeral Home, Aberdeen, Md. 21001				DATE APR 10 1968		<i>Charles Judge</i>		



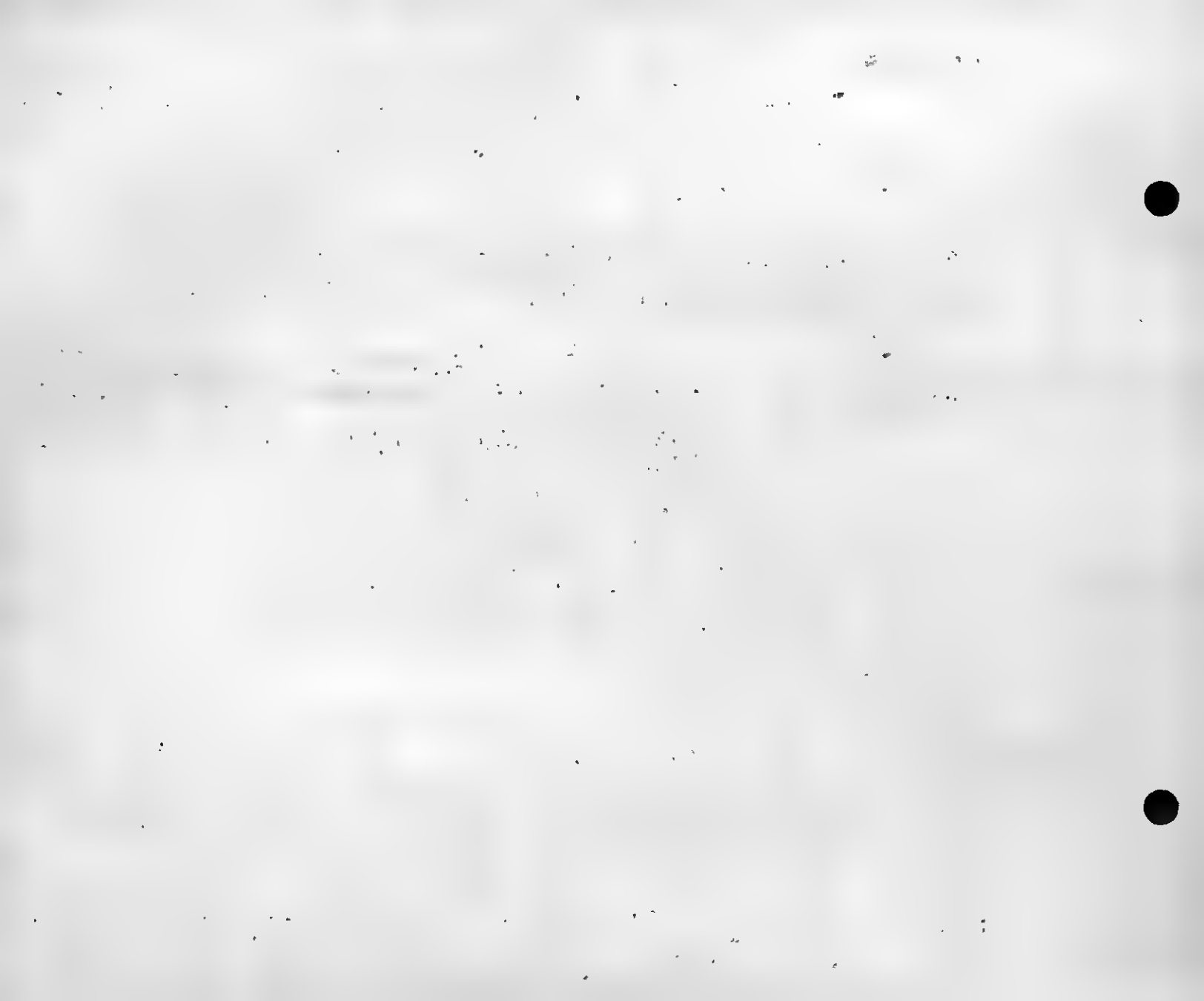
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First <u>Margaret</u> Middle <u>A</u> Last <u>Hendrickson</u>			2a. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>68</u>		2b. HOUR <u>6:58</u> PM
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>October 25, 1875</u>		6. AGE (in years last birthday) <u>92</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Ohio</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Hartford</u> Md.		
10. CITY OR TOWN OF DEATH <u>Harve de Grace</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Hartford Memorial Hosp</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <u>MD</u>	13b. COUNTY <u>Hartford</u>	13c. CITY OR TOWN <u>Forest Hill</u>	3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>Putnam Road</u>	
14. FATHER'S NAME First <u>John</u> Middle <u>Reese</u> Last <u>Margaret</u>		15. MOTHER'S MAIDEN NAME First <u>Margaret</u> Middle <u>Davis</u> Last <u>Davis</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>215-54-0029</u>	17. INFORMANT (Sub) <u>838-5823</u> Address <u>Mr. John R. Hendrickson</u> <u>400-1000 Estates</u> <u>Abingdon, Maryland 21009</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>A.S.C.I.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4121 H.C.T. Pulmonary edema</u>					
19a. DATE OF OPERATION <u>4/15/68</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>4121 H.C.T. Pulmonary edema</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/15/68</u> , 19 <u>68</u> , to <u>4/15/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/15/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edward C. Loo, M.D.</u>		DEGREE <u>M.D.</u>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>4/15/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22e. ADDRESS <u>211 N. Union Ave, Harve de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 18, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pittsburgh, Alleg. Co., PENNA.</u>		
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St</u> <u>Foster Funeral Home</u> <u>Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

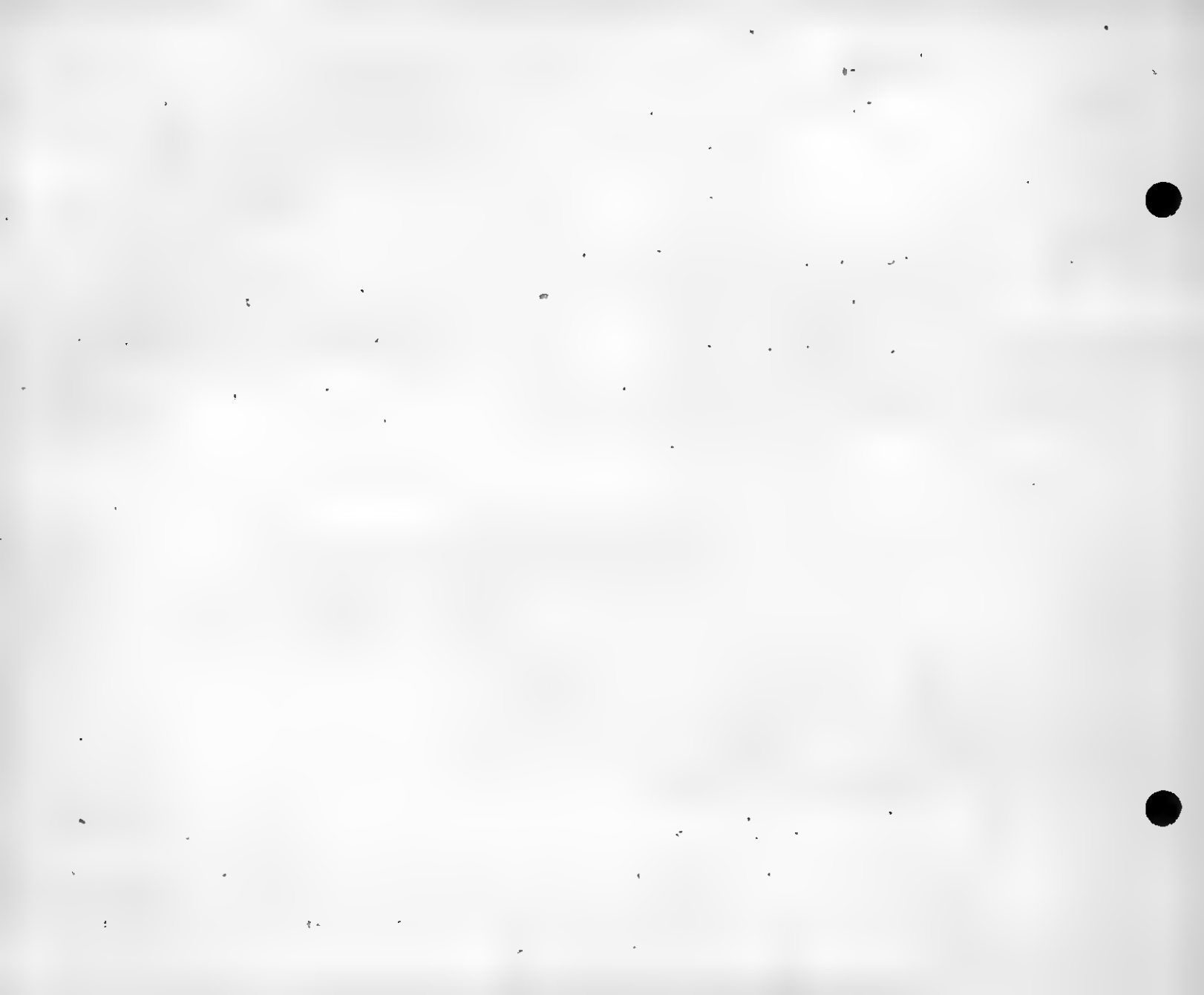


CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Clarence			First L.	Middle Hess	Last Hess	2a. DATE OF DEATH Month April Day 6 Year 68			2b. HOUR 1230 M		
3 SEX Male		4. RACE Caucasian		5 DATE OF BIRTH 24 March 1909		6 AGE (In years last birthday) 59 YRS		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford Md					
10. CITY OR TOWN OF DEATH Aberdeen P. G.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Army			12b. KIND OF BUSINESS OR INDUSTRY Army		
13a U.S. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MD.			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD 1, Box 167		
14 FATHER'S NAME Clarence M. Hess			First Clarence M.	Middle Hess	Last Hess	15. MOTHER'S MAIDEN NAME Geraldine M. Shane			First Geraldine M. Middle Shane Last Shane		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>		(If yes give year or dates of service) 1928- May 54		16b. SOCIAL SECURITY NO. 219-36-1499		17 INFORMANT Genevieve M. Hess, RFD 1, Box 167, Aberdeen					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Coma DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of liver									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 17 March, 19 68 , to 6 April, 19 68 , that (I) (we) last saw the deceased alive on 6 April, 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Roger A. Nosal						DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6 Apr 68	
22d. PHYSICIAN'S NAME (Type) Roger A. Nosal, M.D.						22e. ADDRESS Kirk Army Hospital, A.P.G., MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11 April 68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR Tarring Funeral Home		ADDRESS Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

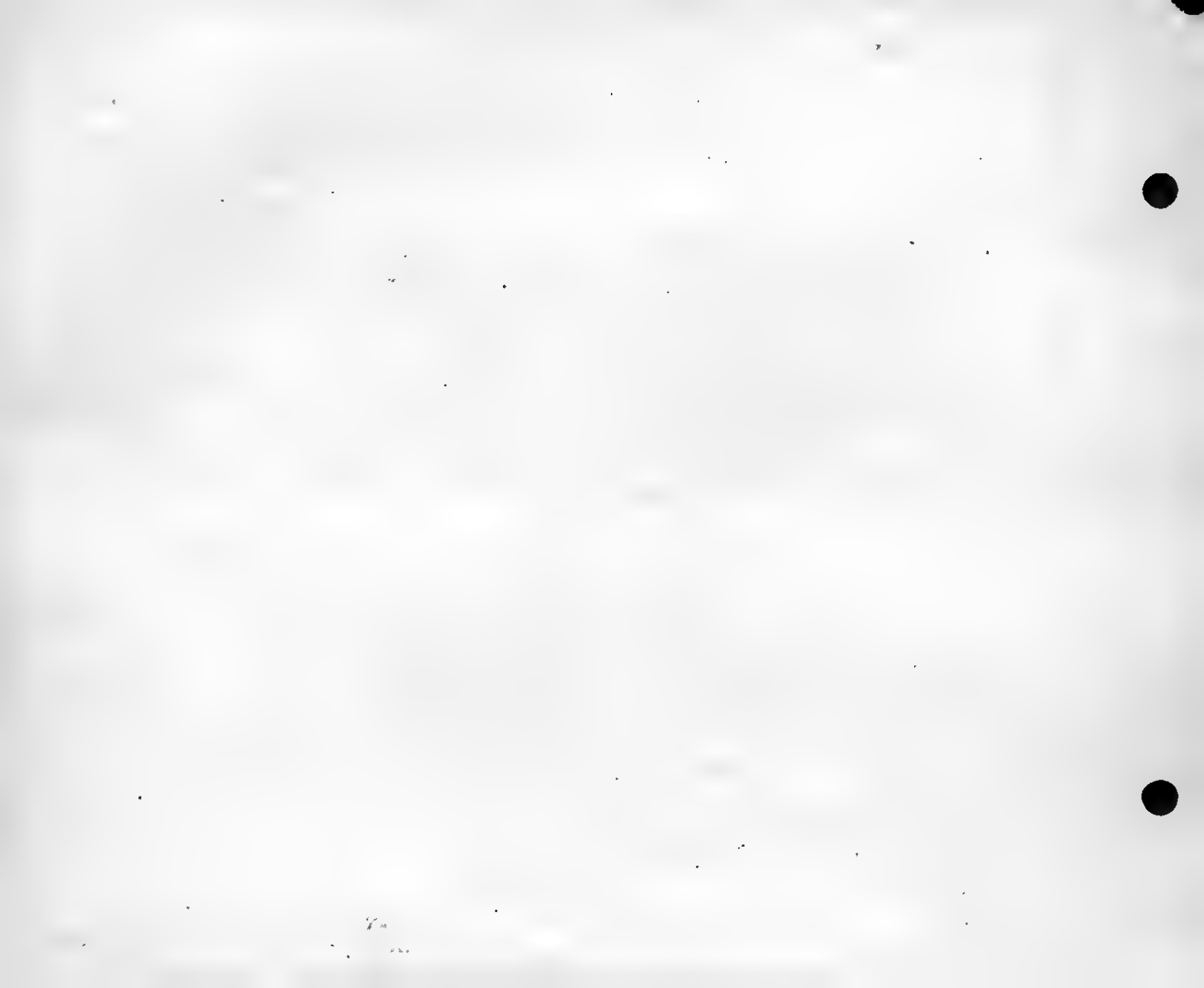


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <u>Wilton E Holliday</u>						2a DATE KNOWN OF DEATH <u>April 18 1968</u>			2b HOUR <u>11</u>		
3 SEX <u>M</u>	4 RACE <u>W</u>	5 DATE OF BIRTH <u>5/14/1889</u>	6 AGE (In years) <u>78</u> YRS	IF UNDER 1 YEAR MONTHS <u>1</u> DAYS <u>1</u>	IF UNDER 24 HRS. HOURS <u>1</u> MIN. <u>18</u>	2c DATE PRONOUNCED DEAD <u>April 18 1968</u>			2d HOUR <u>11</u>		
7a BIRTHPLACE (State or foreign country) <u>W. S. A.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Hartford</u>			Md.		
10 CITY OR TOWN OF DEATH <u>Havre de Grace</u>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Hartford Memorial Hospital</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, or if retired, last)			12b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		
13a USLA RESIDENCE (Where deceased lived, if not full-time residence before admission) STATE <u>Md</u>			13b COUNTY <u>Hartford</u>		13c CITY OR TOWN <u>Havre de Grace</u>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>621 S. Washington</u>		
14 FATHER'S NAME First <u>Benjamin</u> Middle <u>Holliday</u> Last <u>Holliday</u>				15 MOTHER'S MAIDEN NAME First <u>Julia</u> Middle <u>?</u> Last <u>?</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>				16b SOCIAL SECURITY NO <u>Unk</u>		17. INFORMANT <u>Hosp. Records, Havre de Grace Md.</u>			ADDRESS <u>Havre de Grace Md.</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture R Femur</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month Day, Year <u>4-9 1968</u> HOUR <u>4-9</u> A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fell at home</u>						
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>			21c LOCATION Street or R.F.D. No <u></u> City or Town <u>Havre de Grace</u> County <u>Hartford</u> State <u>Md</u>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>De/ H. H. #1</u>				22b DATE SIGNED <u>4-18-68</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <u></u>							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>4/20/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>				23d. LOCATION (City or Town) (County) (State) <u>Havre de Grace Md.</u>			
24. FUNERAL DIRECTOR <u>Pennington & Son, Havre de Grace, Md.</u>				ADDRESS <u></u>				25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>APR 22 1968</u>							



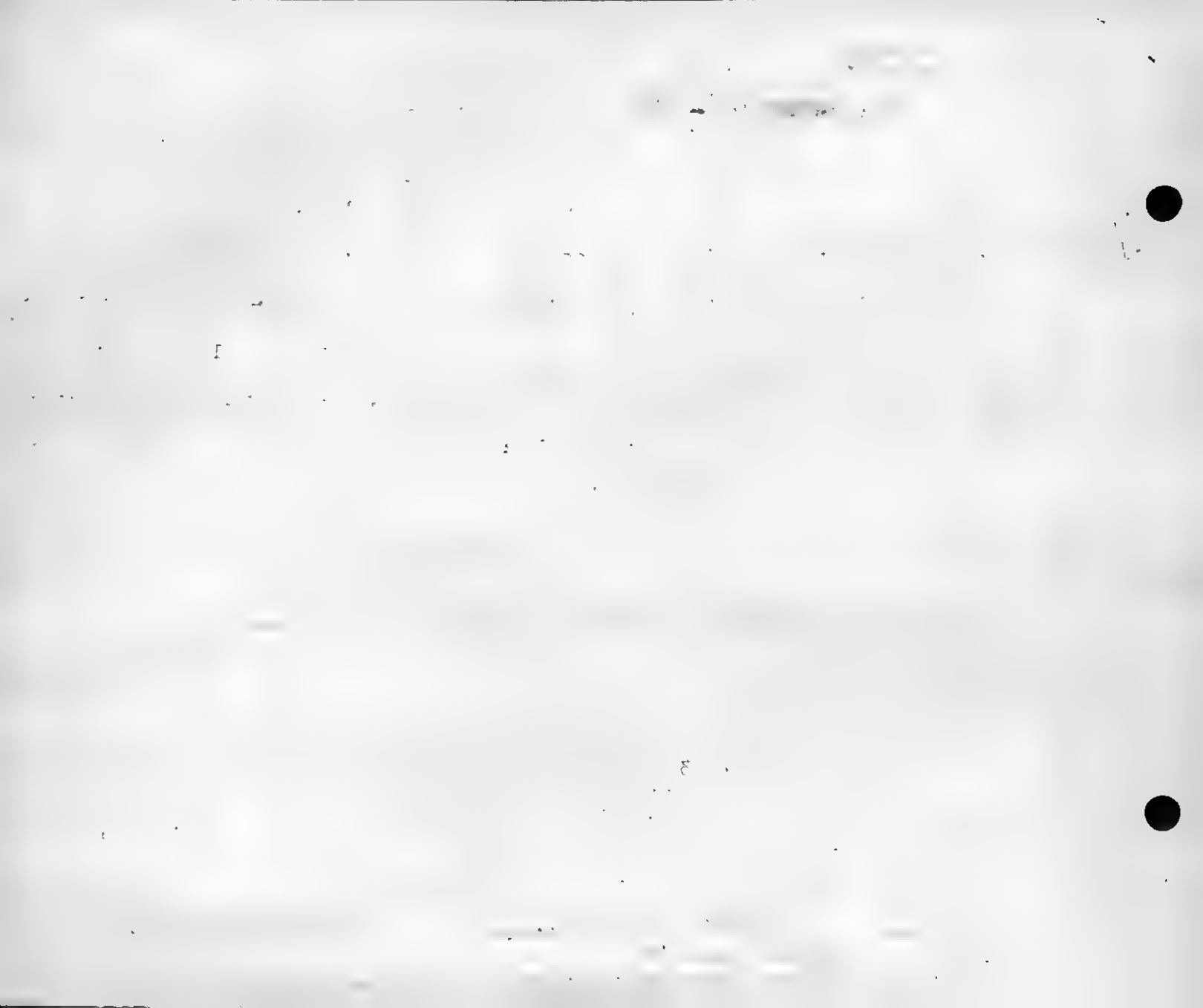
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <u>James James Le Roy Le Roy</u>		First <u>James</u>	Middle <u>Le Roy</u>	Lost	2a. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1968</u>	2b. HOUR <u>0910</u>
3 SEX <u>MALE</u>	4. RACE <u>CAU</u>	5 DATE OF BIRTH <u>APR 30 1968</u>		6 AGE (In years last birthday) YRS. <u>3</u>	7 UNDER 1 YEAR MONTHS <u>5</u> DAYS <u>5</u>	7 UNDER 24 HRS HOURS <u>5</u> MIN <u>5</u>
7a. BIRTHPLACE (State or foreign country) <u>Md</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Harford</u>		
10 CITY OR TOWN OF DEATH <u>Aberdeen Prov Gr</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Kirk Army Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>NA</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md</u>		13b. COUNTY <u>Harford</u>	13c. CITY OR TOWN <u>Aberdeen</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>D-8-4 Pritchard, Aberdeen, Md.</u>	
14. FATHER'S NAME First <u>Dennis</u> Middle <u>Huff</u> Last <u>Huff</u>		15 MOTHER'S MAIDEN NAME First <u>Ginger</u> Middle <u>L</u> Last <u>Huff</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NA</u>		16b. SOCIAL SECURITY NO. <u>NA</u>		17. INFORMANT Address <u>Dennis Huff, D-8-4 Pritchard, Aberdeen, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Distress</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Since Birth</u> <u>Since Birth</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1135</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 30</u> , 19 <u>68</u> , to <u>Apr 30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Apr 30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>George R. Stanley</u>		DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>April 30, 1968</u>
22d. PHYSICIAN'S NAME (Type) <u>GEORGE STANLEY, MAJ, MC</u>		22e. ADDRESS <u>Kirk Army Hospital, APG, Md 21005</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/2/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>The Bolt Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arnett, Oklahoma</u>
24. FUNERAL DIRECTOR <u>Tammy Funeral Home</u>		24b. ADDRESS <u>1015 W. Waverly St. Aberdeen Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

057 11

1. DECEASED NAME (Type or print) First Middle Last INFANT BOY HUFF --B			2a. DATE OF DEATH Month Day Year APRIL 30 1968			2b. HOUR 1210 PM	
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH APRIL 30 1968		6. AGE (In years last birthday) YRS. MONTHS DAYS 8	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Aberdeen Prov Gr		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NA		12b. KIND OF BUSINESS OR INDUSTRY NA	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Dennis Huff		15. MOTHER'S MAIDEN NAME First Middle Last Ginger L Huff		13e. STREET AND NUMBER 8-4, Pritchard, Aberdeen, Md			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NA		16b. SOCIAL SECURITY NO NA		17. INFORMANT Address Dennis Huff, D-8-4 Pritchard, Aberdeen, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 177X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 30 1968 , to April 30 1968 , that (I) (we) last saw the deceased alive on April 30 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George R. Stanley		DEGREE MAJ, MC		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 30, 1968	
22d. PHYSICIAN'S NAME (Type) GEORGE STANLEY, MAJ, MC		22e. ADDRESS Kirk Army Hospital, APG, Md 21005					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/2/1968		23c. NAME OF CEMETERY OR CREMATORY Gr Bol Cemetery		23d. LOCATION (City or Town) (County) (State) Harford, Oklahoma	
24. FUNERAL DIRECTOR Walter H. H. H. H.		ADDRESS Walter H. H. H. H.		25a. REC'D BY REGISTRAR MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-D-NAME (Type or print) <u>JOHN HUGH HUGHES</u>			2a. DATE OF DEATH <u>4</u> Month <u>28</u> Day <u>68</u> Year		2b. HOUR <u>11:40 A</u> M
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>May 2, 1908</u>	6. AGE (In years lost birthday) <u>59</u> YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>MD.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>HARFORD</u> Md.		
10. CITY OR TOWN OF DEATH - <u>DARLINGTON</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>HUGHES RD.</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Lumber Dealer</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>	13b. COUNTY <u>Harford</u>	13c. CITY OR TOWN <u>DARLINGTON</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>HUGHES RD</u>	
14. FATHER'S NAME First <u>GEO.</u> Middle <u>WASHINGTON</u> Last <u>HUGHES</u>	15. MOTHER'S MAIDEN NAME First <u>ELLA</u> Middle <u>MAC</u> Last <u>SMITH</u>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give year or dates of service) <u>2/8-29-0353</u>			
16b. SOCIAL SECURITY NO <u>218-29-0353</u>			17. INFORMANT <u>Catherine Hughes</u> Address <u>Darlington</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALNUTRITION</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMATOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Cancer of Colon</u> (c) <u>Cancer of Colon</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>6 mos</u> <u>1 year</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>1.</u>					
19a. DATE OF OPERATION <u>13 Mar '67</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma Colon</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office buildings, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>67</u> , to <u>Apr</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>23 Apr</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Wm. K. Brendle</u>	DEGREE <u>MD</u>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>4-28-68</u>		
22b. PHYSICIAN'S NAME (Type) <u>Wm. K. Brendle</u>	22e. ADDRESS <u>HAUCE de Grace, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 1, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u>	23d. LOCATION (City or Town) <u>Darlington</u> (County) <u>Harford Co.</u> (State) <u>Md.</u>		
24. FUNERAL DIRECTOR <u>John H. Harkins</u>	Address <u>Delta, Pa.</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>	DATE <u>MAY 11 1968</u>	25b. REGISTRAR'S SIGNATURE	

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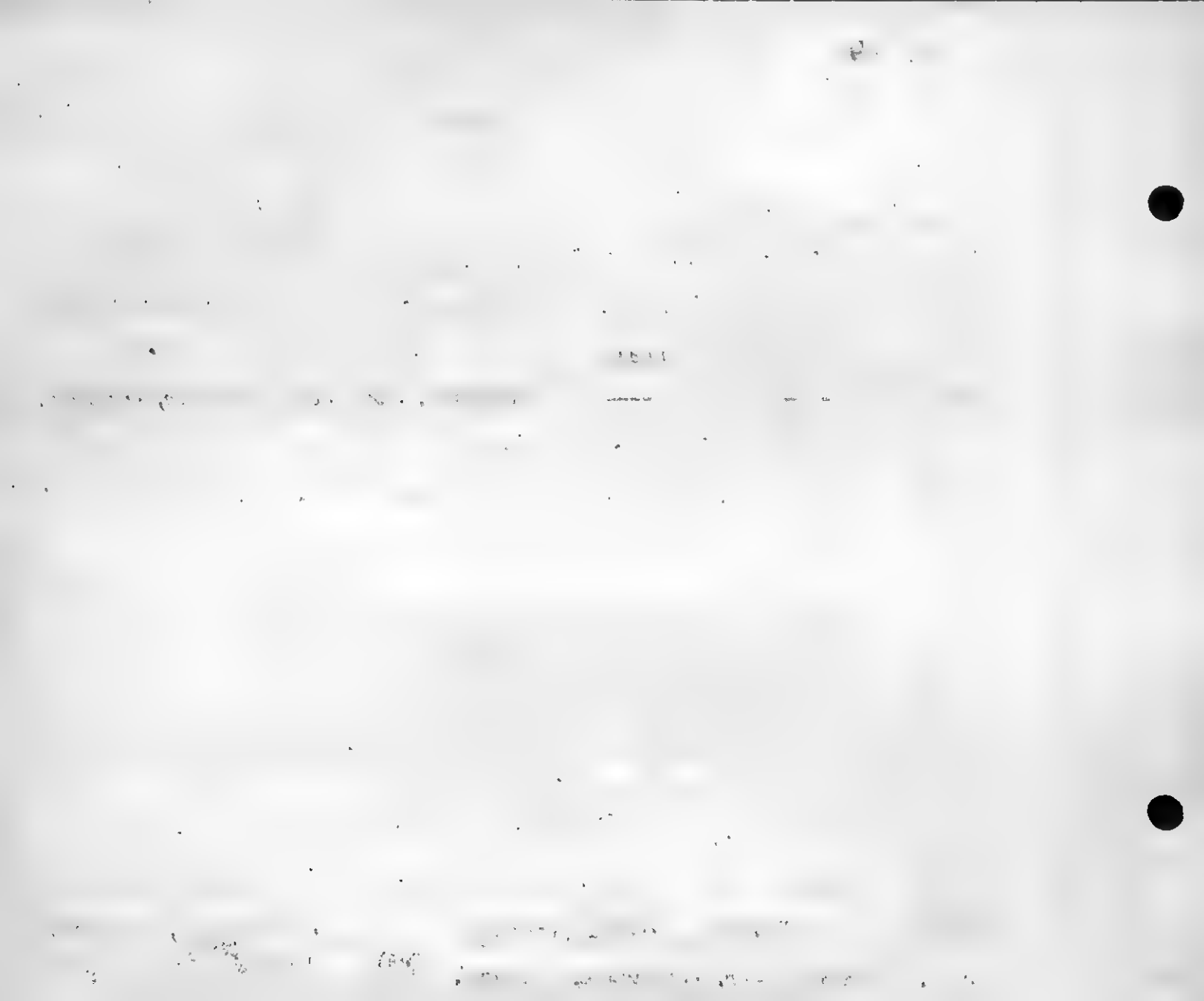
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

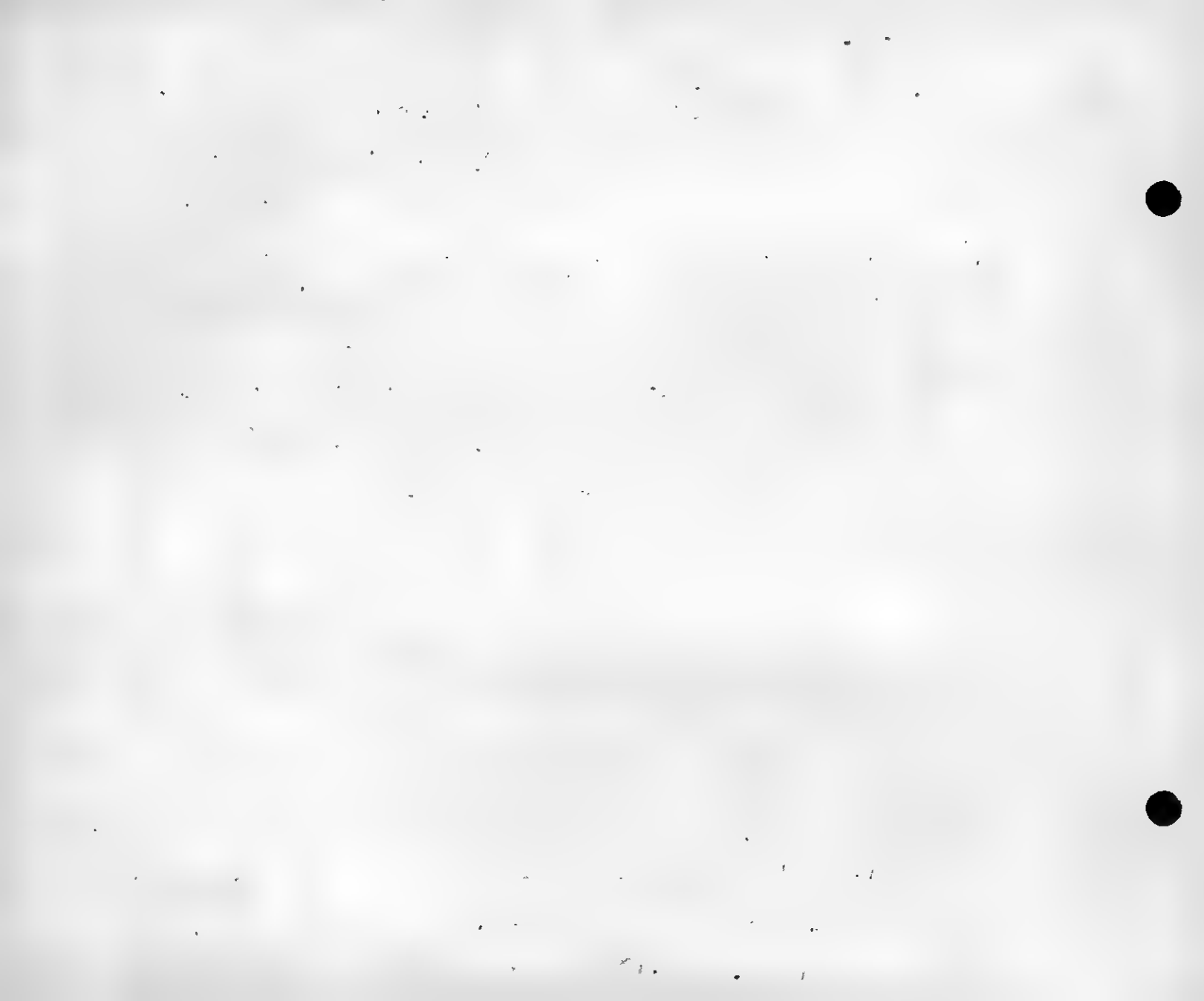
1. DECEASED-NAME (Type or print) First: Baby, Middle: Boy, Last: HUSS			2a. DATE OF DEATH Month: Apr., Day: 26, Year: 1968			2b. HOUR 5:15 PM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 4-25-68		6. AGE (in years last birthday) YRS. MONTHS DAYS 2		7. IF UNDER 24 HRS. IF UNDER 1 YEAR	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH HAURE de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of work ng life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAURE de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 237 Seneca Ave	
14. FATHER'S NAME First: Rudolph, Middle: , Last: HUSS			15. MOTHER'S MAIDEN NAME First: Margaret L., Middle: WADE, Last: HUSS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. ---		17. INFORMANT Margaret W. HUSS, HAURE de Grace, Maryland.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ANOXIA DUE TO, OR AS A CONSEQUENCE OF PATENT DUCTUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COARCTATION OF AORTA + ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF CONGENITAL (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from April 25, 1968, to April 26, 1968, that (I) (we) last saw the deceased alive on April 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Norman M.D.					22c. DATE SIGNED 4.26.68		22d. PHYSICIAN'S NAME (Type) R. Norman M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/27/1968		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City or Town) (County) (State) Port Deposit, Maryland.			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland.					25a. REC'D BY REGISTRAR DATE MAY 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <i>Thelma Elizabeth Hutton</i>						2a. DATE OF DEATH Month <i>4</i> Day <i>30</i> Year <i>68</i>			2b. HOUR <i>6 P M</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>SEPT. 16, 1905</i>			6. AGE (In years last birthday) <i>62</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) <i>Penna</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED: <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Hartford</i> Md			
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Pa</i>			13b. COUNTY <i>YORK</i>			13c. CITY OR TOWN <i>Delta</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>MAIN STREET</i>	
14. FATHER'S NAME First Middle Last <i>George Steven Hamilton</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>Mabel McAllister</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO. <i>162-22-7745</i>			17. INFORMANT <i>Paul F. Hutton</i>			Address <i>DELTA, PA.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Infectious + Urinary Obstruction</i> <i>1880</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma Ovary</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1/15/68</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Irvin L. Waxsman</i>						22c. DATE SIGNED <i>4/30/68</i>						
22d. PHYSICIAN'S NAME (Type) <i>IRVIN L. WAXSMAN M.D.</i>						22e. ADDRESS <i>HAVRE DE GRACE, MD.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>5-3-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>SLATEVILLE</i>			23d. LOCATION (City or Town) (County) (State) <i>DELTA, YORK, PA.</i>			
24. FUNERAL DIRECTOR <i>JOHN H. HARKINS</i>						ADDRESS <i>DELTA, PA.</i>			25a. REC'D BY REGISTRAR DATE <i>MAY 6 1968</i>			
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Pylesville		c LENGTH OF STAY IN lb 41 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Quarry Road		d STREET ADDRESS Quarry Road	
3. NAME OF DECEASED (Type or print) BESSIE FRANCES JONES		4 DATE OF DEATH Month April Day 10 Year 1968	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 16, 1892
9 AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Delta, Penna.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Bulette		14. MOTHER'S MAIDEN NAME Carrie Singleton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-22-5044	
17 INFORMANT William A. Jones, Pylesville, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Cardiac Failure DUE TO (b) Arteriosclerotic CVD disease DUE TO (c) Arteriosclerotic CVD disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 to April 10, 1968 , that (I) (we) last saw the deceased alive on April 9, 1968 , and that death occurred at 10:10 M, from causes and on the date stated above.			
22a. SIGNATURE Joseph A. Hunt		22b DATE SIGNED 4/12/68	
22c PHYSICIAN'S NAME (Type) Leosiah A. Hunt MD		22d ADDRESS Delta, Penn.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF April 13, 1968	
23c. NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery Delta, York Co., Pa.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR John H. Harkins		25a. REC'D BY REGISTRAR DATE APR 16 1968	
ADDRESS Delta, Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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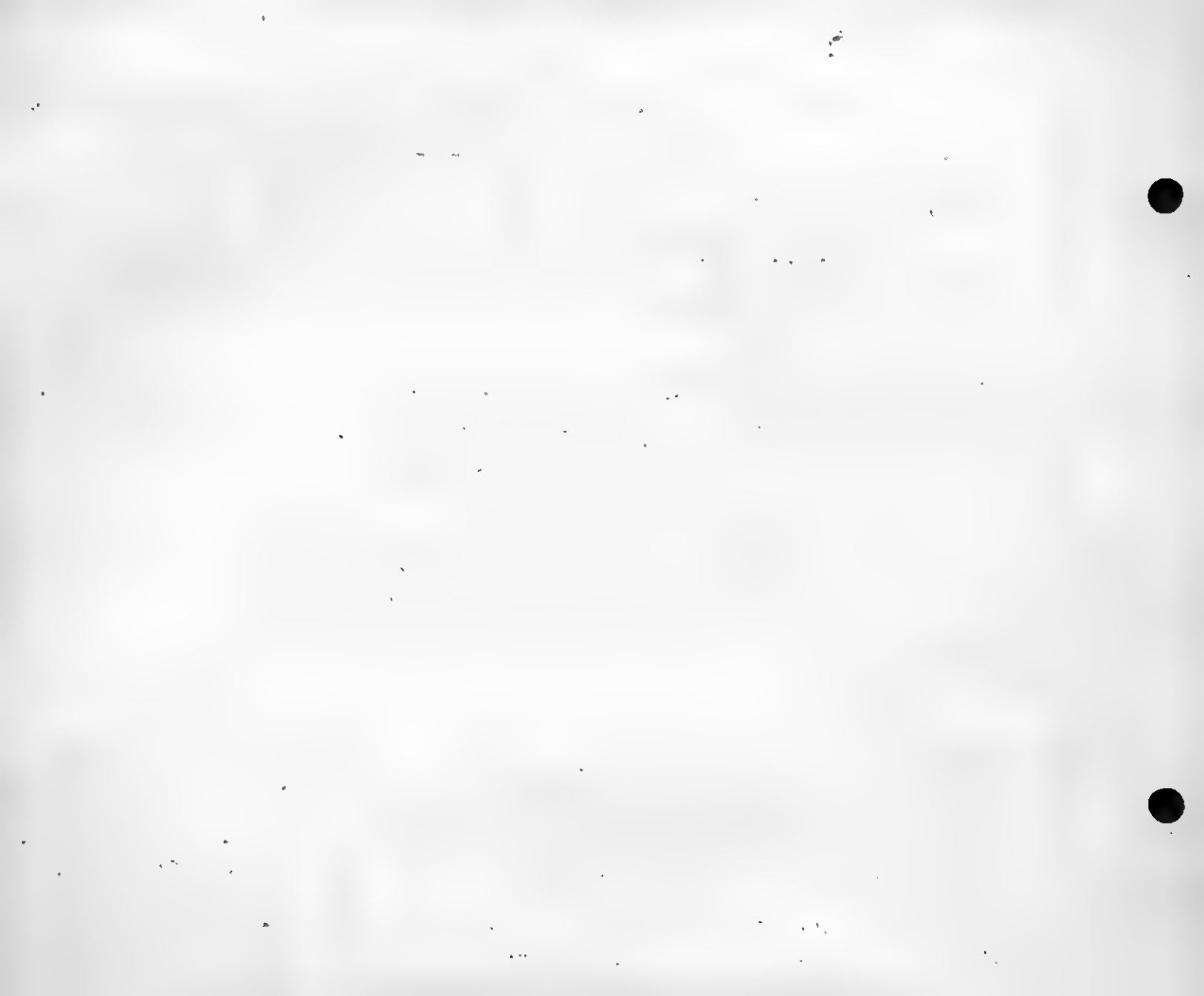
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Emory C. Jones			2a. DATE OF DEATH Month 4 Day 24 Year 1968		2b. HOUR 6:30 MIN. M
3 SEX male	4. RACE white	5. DATE OF BIRTH 09-10-89		6. AGE (In years lost birthday) 78 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Hayre de Grace, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Joppatowne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 803 Chatfield Road	
14. FATHER'S NAME First Middle Last David Jones		15. MOTHER'S MAIDEN NAME First Middle Last Annie Lockner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) Unknown		16b. SOCIAL SECURITY NO. 218-05-1315		17. INFORMANT Address Mrs. Merry M. Brown-803 Chatfield Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac De-compensation 4/22/68 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4221 (b) A.S. C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2-3 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus + Embolus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> —at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/12 , 19 68 , to 4/24 , 19 68 , that (I) (we) last saw the deceased alive on 4/24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Loo		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/24/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Hayre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial	Apr 27, 1968	Meadowridge		Howard Co. Md.	
24. FUNERAL DIRECTOR Donovan Funeral Home		ADDRESS 3818 Baltimore Rd. Md.		25a. REC'D BY REGISTRAR Charles Judge DATE APR 26 1968	

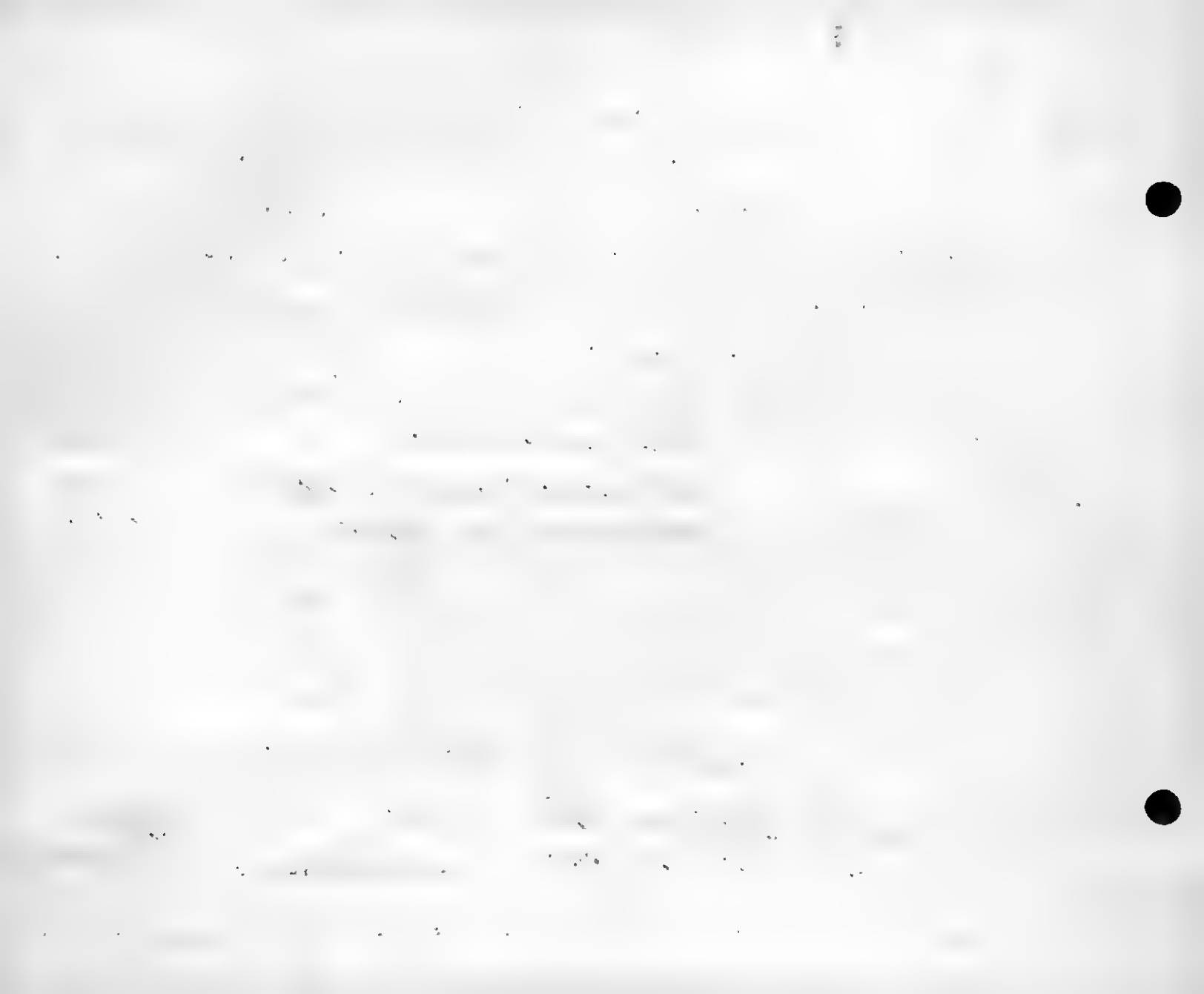


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VR A15 (1)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Albert J. Lacoste						2a. DATE OF DEATH Month Day Year 4 5 1968			2b. HOUR M M			
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH 8-30-1909		6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Louisiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford			Md.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosehill Farm Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trainer of Horses			12b. KIND OF BUSINESS OR INDUSTRY Selfempl			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.				13b. COUNTY ✓		13c. CITY OR TOWN Charlestown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last Peare J. Lacoste				15. MOTHER'S MAIDEN NAME First Middle Last Ernestine Roudel								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 136-05-9310		17. INFORMANT Box 37 Address Cornellia M. Lacoste Rose Hill Fallston 21047						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESP FAILURE</u> 10a1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC CARCINOMA OF BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF LUNG</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 6 MO 2 YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 16.3x												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 15, 1968</u> , to <u>4 APR, 1968</u> , that (I) (we) last saw the deceased alive on <u>MAR 25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>H. P. Sidwell MD</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5 APR 1968</u>				
22d. PHYSICIAN'S NAME (Type) <u>H. P. SIDWELL MD</u>						22e. ADDRESS <u>401 FRANKLIN ST BELAIR MD</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-8-1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md.						
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7461 Belair Road</u>						25a. RECEIVED BY REGISTRAR DATE <u>APR 8 - 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



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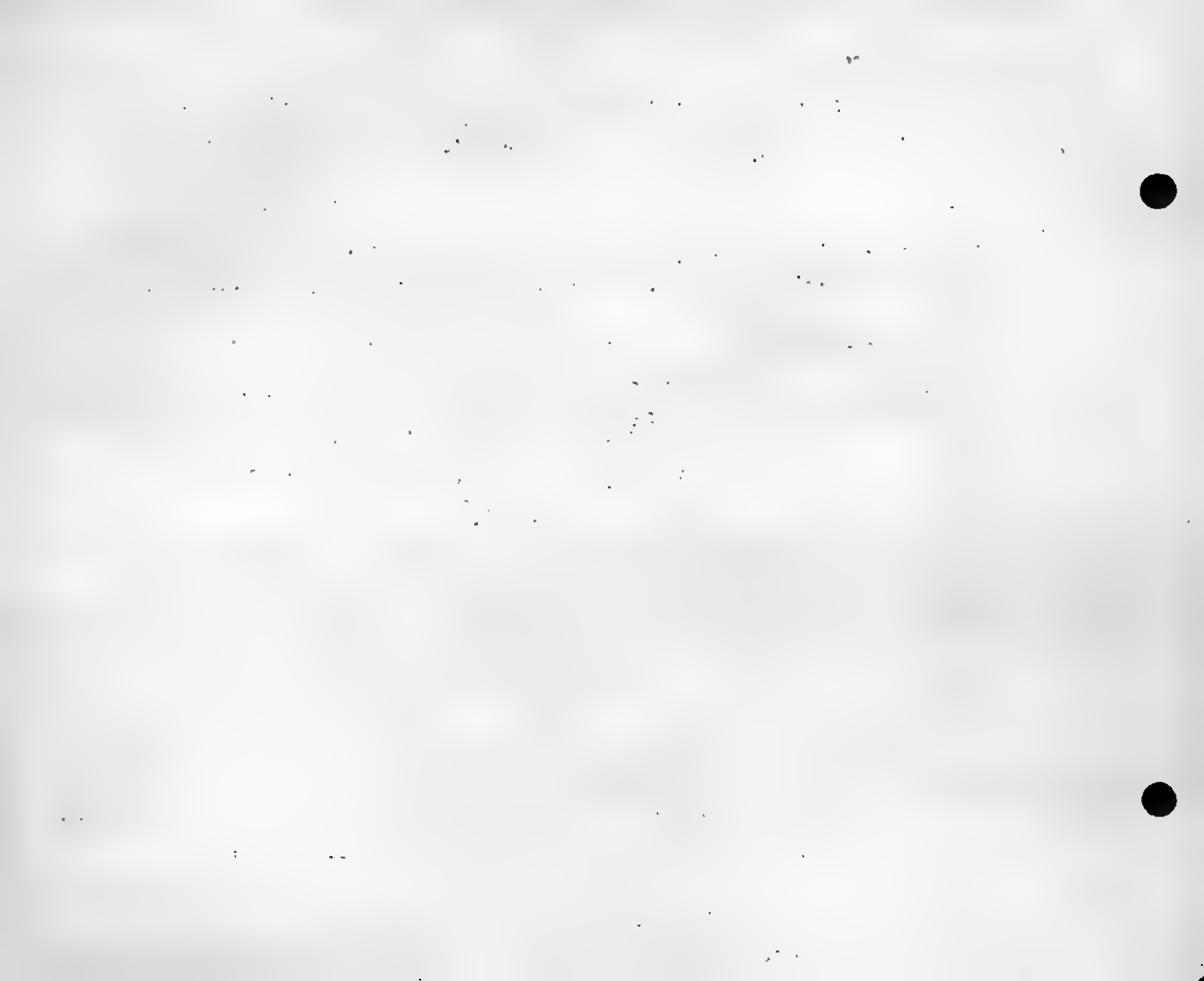
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VR 15154
30M REV 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) George Bernard Meyer			2a. DATE OF DEATH Month April Day 14 Year 1968			2b. HOUR 10⁵⁶ P.M.					
3. SEX male		4. RACE white		5. DATE OF BIRTH Jul-2, 1905		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) CONN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD.					
10. CITY OR TOWN OF DEATH Haure de Grace, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Veterinarian		12b. KIND OF BUSINESS OR INDUSTRY Self-employed					
13a. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2225 Rossmore Drive, J. 100, J. 100			
14. FATHER'S NAME First George Middle — Last Meyer			15. MOTHER'S MAIDEN NAME First Anna Middle — Last Bakalar								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 203-22-7160		17. INFORMANT Robert L. Meyer, JR., Son, 301 W. Preston St., Baltimore, Md.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial inf. DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lajoš Jozsi		DEGREE —		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 14, 1968	
22d. PHYSICIAN'S NAME (Type) Lajoš Jozsi		22e. ADDRESS Haure de Grace, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE April 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Joppa Harford Md.					
24. FUNERAL DIRECTOR Obert H. McCombs		24a. ADDRESS Con, Shingon, Md.		25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



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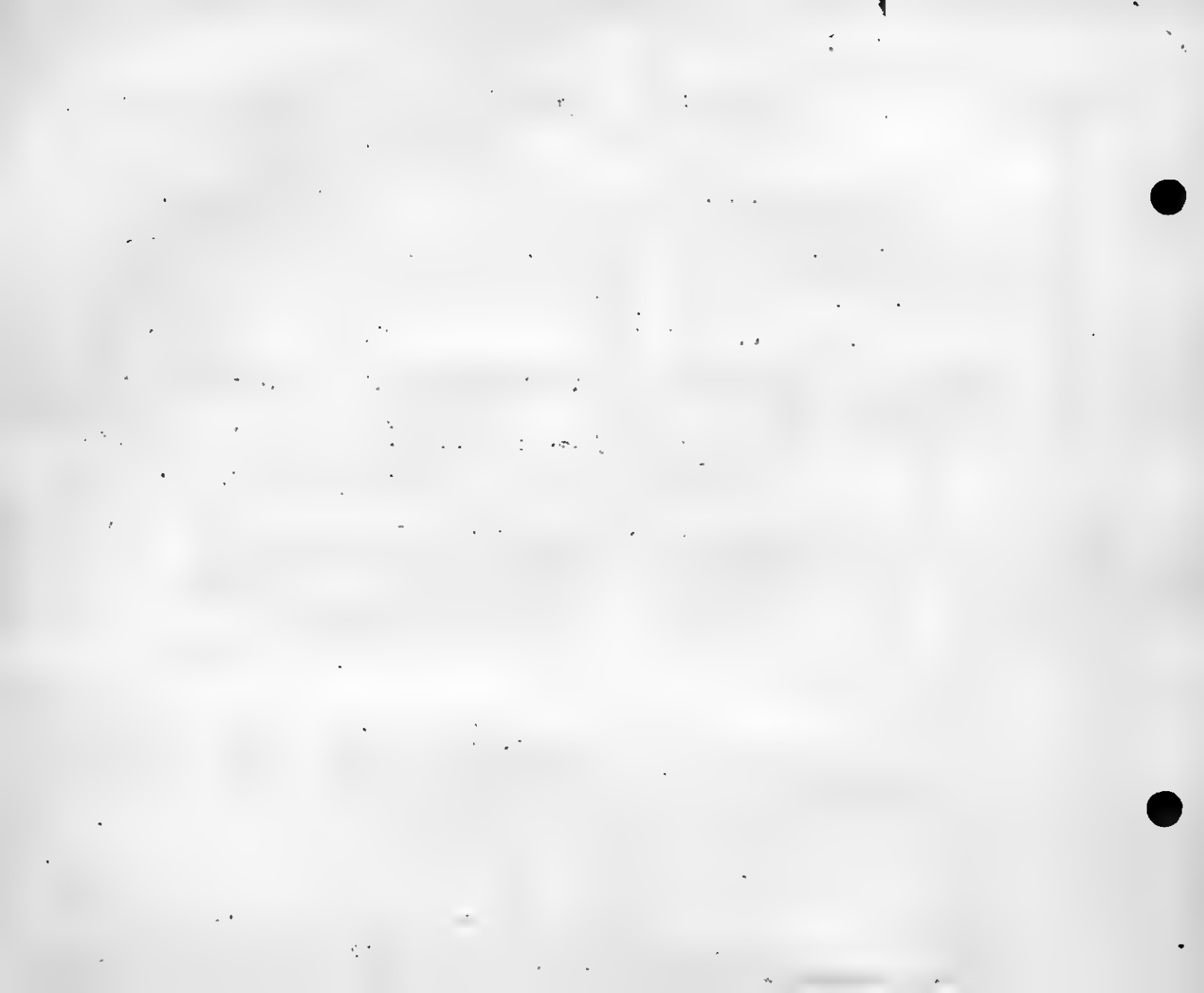
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VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Lawrence IRA Mitchell			2a. DATE OF DEATH Month Day Year April 18 1968			2b. HOUR 12:20 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 22 Nov. 1916		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.				
10. CITY OR TOWN OF DEATH HAVER de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Merchant			12b. KIND OF BUSINESS OR INDUSTRY General Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY HARFORD		13c. CITY OR TOWN Churchville		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD #1 Box 53	
14. FATHER'S NAME First Middle Last Seymour R. Mitchell			15. MOTHER'S MAIDEN NAME First Middle Last Kate Ritter (D)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO 212-16-9076		17. INFORMANT Address Nancy Mitchell, Churchville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extensive anterior myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary thrombosis</u> Condit'ns, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 5 hrs. 5 hrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4/17, 1968, to 4/18, 1968 that (I) (we) last saw the deceased alive on 4/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edward C. Loo, M.D.				DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/18/68				
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				22e. ADDRESS Haver de Grace, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 20 Apr. 68		23c. NAME OF CEMETERY OR CREMATORY St Marys Episcopal Cemetery		23d. LOCATION (City or Town) (County) (State) Bel Air, Maryland				
24. FUNERAL DIRECTOR Walter Macomber Jr.				Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI DEATH MATED <input type="checkbox"/> Month Day Year			
Gordon		Bruce		Moore				April, 13, 1968 2:20			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year		
Male	White	May 19, 1951		16 YRS					April Day 13 Year 19 68 2:50		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		USA				Harford		Md			
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
Havre de Grace, Md.				Harford Memorial Hospital, Harford				Student			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md.				Harford		Edgewood		318 Crestwood Drive,			
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last		
Gordon			E. Moore			Yvonne			Siler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
no				215-58-1452		Norman C. Moore, 42 Mitchell Ave., Aberdeen				Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Cervicle Vertebrae</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
				HOURLY MIN. 4-13 19 68		Auto Accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State			
				Willoughby Beach Road,		Edgewood,		Harford, Md			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED			
Gerald C. Palmer		Gerald C. Palmer, M.D.				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		April 13-68			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)			
Burial		April 16, 1968		Harford Memorial Gardens		Aldino		Harford Md			
24. FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
Howard K. McComas & Son, Abingdon, Md.						DATE APR 16 1968		Charles Judge			

FOR STATE HEALTH DEPT.

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Items 21 Film 300
4-8-68 ams
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <i>Nettie Lee Moore</i>		2a DATE KNOWN OF DEATH MATED <input type="checkbox"/> 4-1 19 68		2b HOUR 11:35 M	
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH 6/22/1885	6 AGE (in years last birthday) 82 YRS	7 UNDER 24 HRS MONTHS DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD Month <i>Apr</i> Day <i>1</i> Year <i>19 68</i>
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Harford</i>		10. CITY OR TOWN OF DEATH <i>Harford</i>			
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if not regular) <i>Rel. Companion</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Cecil</i>		13c CITY OR TOWN <i>Rising Sun</i>	
13d INSIDE CITY MAP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Cherry St.</i>			
14 FATHER'S NAME First Middle Last <i>George Powell</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Netta Edwards</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16b SOCIAL SECURITY NO. <i>224-32-7228</i>		17. INFORMANT <i>Mrs. Chas. T. Crothers</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Femur</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>3-20 19 68</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell</i>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory office, building, etc.) <i>Nursing Home</i>		21f LOCATION Street or R.F.D. No. City or Town County State <i>Havre de Grace Harford Md.</i>	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>4-1-68</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>4/5/68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Morris Cemetery</i>	
23d LOCATION (City or Town) (County) (State) <i>Deltaville Middlesex Va.</i>		24 FUNERAL DIRECTOR <i>Richard L. Goodie</i>			
25a REC'D BY REGISTRAR DATE <i>APR 3 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Vivian M. NORTON			2a. DATE OF DEATH Month 4 Day 7 Year 68			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7 FEB 24, 1897		6. AGE (in years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Vermont		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Hartford Md.			
10. CITY OR TOWN OF DEATH Harve-de-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) UNK		12b. KIND OF BUSINESS OR INDUSTRY UNK			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Hartford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD Box 635 SHARON ROAD	
14. FATHER'S NAME First Chester Guy Middle ETT Last NORTON			15. MOTHER'S MAIDEN NAME First INEZ Middle NORTON Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK		16b. SOCIAL SECURITY NO. UNK		17. INFORMANT Address HARTFORD MEMORIAL HOSP. RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary failure DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema & pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-7, 1968 , to 4-7, 1968 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. Chung for Leyte		DEGREE H. CHUNG FOR LEYTE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Apr 8, 68			
22d. PHYSICIAN'S NAME (Type) H. CHUNG FOR LEYTE		22e. ADDRESS HARTFORD MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/7/1968		23c. NAME OF CEMETERY OR CREMATORY WOODLAND Cemetery		23d. LOCATION (City or Town) (County) (State) KEENE CHESHIRE N.H.			
24. FUNERAL DIRECTOR Pennington + Son Harve de Grace Md		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 15 1968		25b. REGISTRAR'S SIGNATURE William J. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

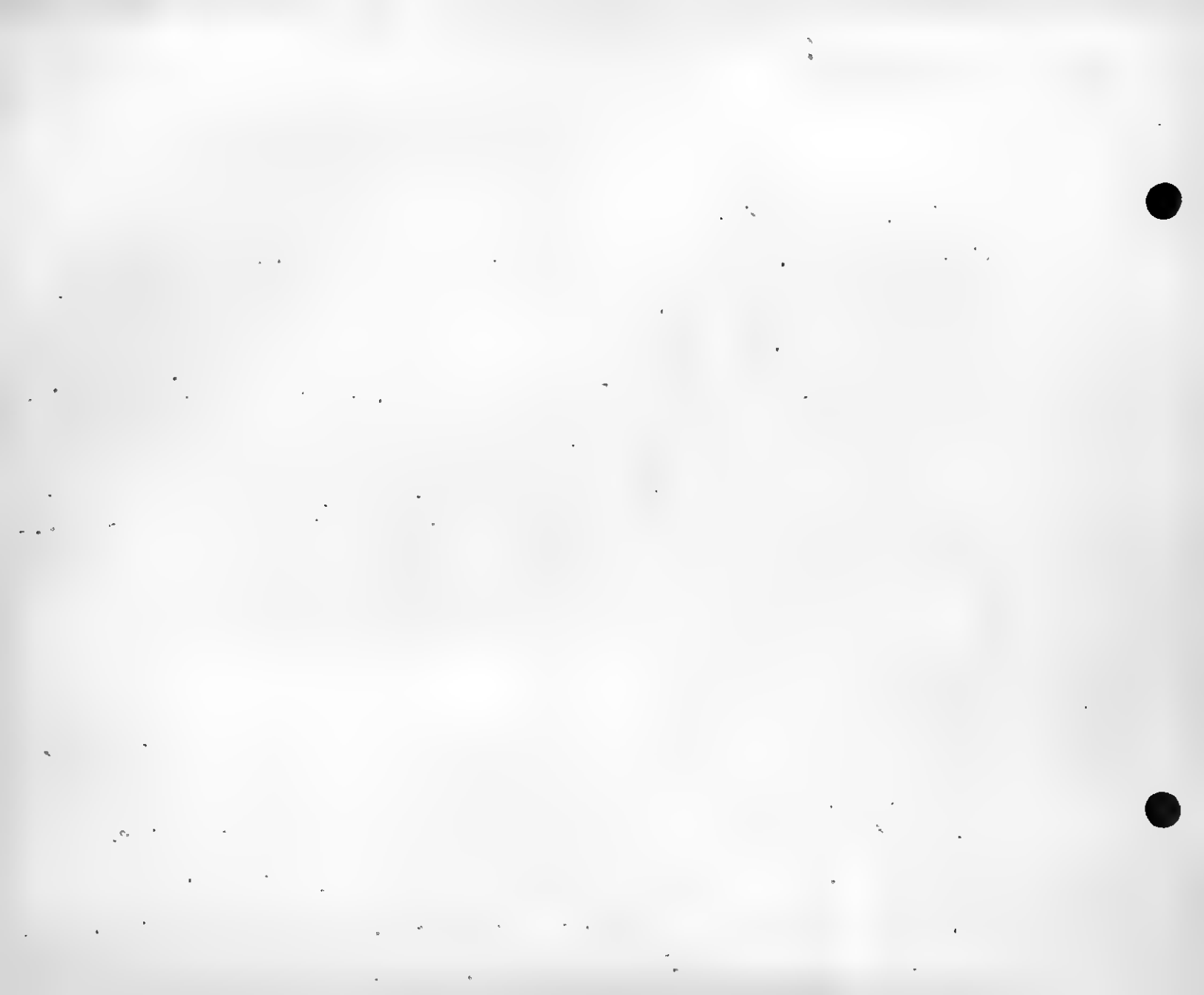
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 175 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last CORA M. PENNINGTON			2a. DATE OF DEATH Month 4 Day 15 Year 68			2b. HOUR 1:00 P.M.			
3 SEX Female		4 RACE white		5. DATE OF BIRTH 2-15-1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Rocks, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address) Citizen's Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 684 Star Rt.	
14. FATHER'S NAME First Middle Last Elisha Warner Iley			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Norris						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No ---			16b. SOCIAL SECURITY NO 168-14-1861 215-40-9607		17 INFORMANT Margaret P. Jones Forest Hill, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PT cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fract spine, Multiple rib fractures</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4-17-68						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21050 6 wks 3 mos			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. Jan 25 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) Injury to right chest sustained				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) at home		21f. LOCATION Street or R.F.D. No Forest Hill Harford Md					
22a. I certify that (I) (this hospital) attended the deceased from 2/17, 1968, to 4/15, 1968, that (I) (we) last saw the deceased alive on 4/14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. H. Sadowsky M.D.			DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/16/68		
22d. PHYSICIAN'S NAME (Type) W. H. Sadowsky			22e. ADDRESS Havre de Grace, Md. 21078						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/17/1968		23c. NAME OF CEMETERY OR CREMATORY William Watters Mem.		23d. LOCATION (City or Town) (County) (State) Coopstown, Harford, Md.			
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.				25a. REC'D BY REGISTRAR DATE 100 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
730
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street				c. LENGTH OF STAY IN 1b 13 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Horeb Road				d. STREET ADDRESS Mt. Horeb Road			
3. NAME OF DECEASED (Type or print) First Sallie Middle Denton Last Ragan				4. DATE OF DEATH Month April Day 4 Year 19 68			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/3/1873		9. AGE (In years last birthday) 95 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Grange City, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME O. B. Denton				14. MOTHER'S MAIDEN NAME Leah Newman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-50-4065		INFORMANT Address Mrs. Mildred R. Phillips RD 1 Box 167 Street, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoarthritis						INTERVAL BETWEEN ONSET AND DEATH 2 days 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from May 12 , 19 67 , to Apr. 4 , 19 68 that (I) (we) last saw the deceased alive on Apr. 3 , 19 68 , and that death occurred at 3 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert Barthel				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Apr. 4/68	
22c. PHYSICIAN'S NAME (Type) Robert Barthel				22d. ADDRESS Box #4, Forest Hill, Md. 21050			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Park		23d. LOCATION (City, town or county) (State) Lexington, Kentucky	
24. FUNERAL DIRECTOR ADDRESS Charles E. Kurtz Jarrettsville, Md.				25a. REC'D BY REGISTRAR APR 5 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR 15 (3-61)
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Mary Elizabeth Schafer			2a. DATE OF DEATH Month April Day 23 Year 1968			2b. HOUR 7A. M			
3 SEX Female		4. RACE White		5 DATE OF BIRTH October 30, 1903		6 AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford County, Md.			
10. CITY OR TOWN OF DEATH Bel Air		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 505 Maitland Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 505 Maitland Avenue	
14. FATHER'S NAME First Middle Last John C. Wiker			15. MOTHER'S MAIDEN NAME First Middle Last Edna Louise Moore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 215-32-1602		17 INFORMANT (Husband) 838-7321 Mr. Peter J. Schafer		Address 505 Maitland Ave, Bel Air, Md. 21014			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive CVD disease TIPO DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-17, 1932 to 7-23, 1968 , that (I) (we) last saw the deceased alive on 4-22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gerald C. Palmer				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED April 23, 1968			
22d. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.				22e. ADDRESS S. Main St., Bel Air, Md. 21014					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 25, 1968		23c. NAME OF CEMETERY OR CREMATORY St. John's Episcopal Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Kingsville, Balto. Co., Md.			
24 FUNERAL DIRECTOR Joseph William Foster				W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR APR 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

100

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

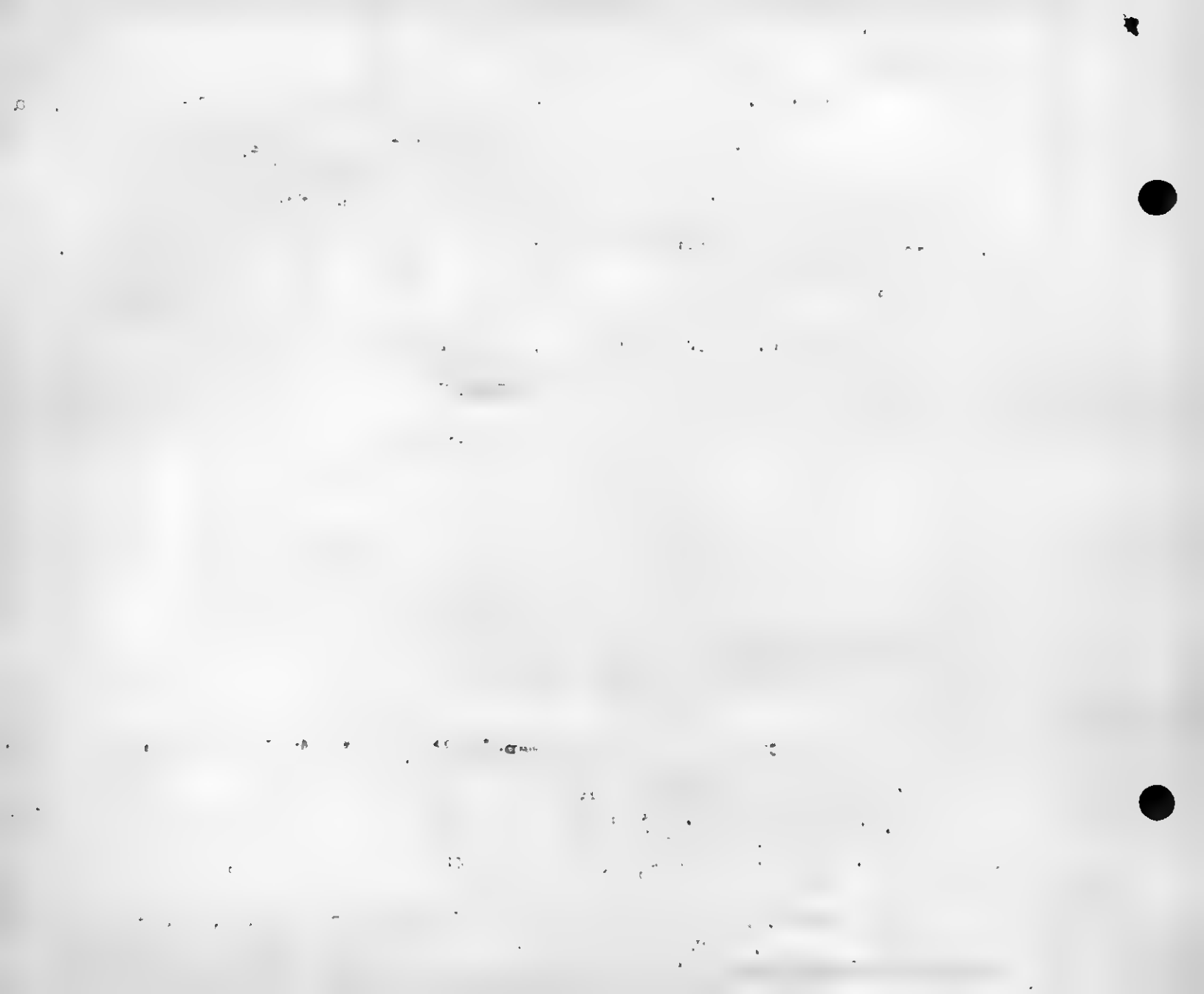
CERTIFICATE OF DEATH

55735

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
CHARLES		E	TORRENCE	APRIL Month 18 Day 1968 Year		4:00 PM			
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
MATE	CAU		12 May 1918		69 YRS.		IF UNDER 24 HRS.		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				Harford Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Aberdeen Prov Gr			Kirk Army Hospital			Soldier		U.S. Army	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Md			Harford	Aberdeen	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	33 Baker St			
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Charles E.			Torrence Sr (D)	Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
Yes			WW-II		Helen Torrence 33 Baker St Aberdeen Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Carcinoma of tail of pancreas									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (the hospital) attended the deceased from April 18, 1968, to April 18, 1968, that (I) (we) last saw the deceased alive on April 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
Lawrence W. Koch, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		April 18 1968		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
LAWRENCE KOCH, CPT, MC					Kirk Army Hospital, APG, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		20 Apr. 68		Harford Memorial Gardens		Aberdeen, (Harford) Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tarring Funeral Home Aberdeen, Md. 21001				DATE APR 22 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05736 CERTIFICATE OF DEATH 05736									
1. DECEASED-NAME (Type or print) LEE R WILLIAMSON			2a. DATE OF DEATH Month Day Year APRIL 18 1968			2b. HOUR 3:00 PM			
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH 11 FEB 1917		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Worthville, NC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Aberdeen Prov Gr		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SOLDIER		12b. KIND OF BUSINESS OR INDUSTRY US Army			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9 OAK Street	
14. FATHER'S NAME First Middle Last William O. Williamson			15. MOTHER'S MAIDEN NAME First Middle Last Ida Freeman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If no, or unknown) 1938-1968			16b. SOCIAL SECURITY NO. 242-035435		17. INFORMANT Army Personnel Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, massive unexplained 514X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 522X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from April 18, 1968, to April 18, 1968, that (I) (we) saw the deceased alive on April 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lawrence W. Koch MD				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 18, 1968			
22d. PHYSICIAN'S NAME (Type) LAWRENCE KOCH, CPT, MC				22e. ADDRESS Kirk Army Hospital, APG, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/23/68		23c. NAME OF CEMETERY OR CREMATORY Post Cemetery		23d. LOCATION (City or Town) (County) (State) Aberdeen Prov. Gr. Harford Md.			
24. FUNERAL DIRECTOR Lee J. Patterson & Sons, Pottersville, Md.				25a. REC'D BY REGISTRAR DATE APR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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1924

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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10/25/88 10:00 AM

1. The first step is to identify the problem or question that needs to be answered.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05737

1. DECEASED NAME (Type or print) ROBERT R. YOUNG		2a. DATE OF DEATH Month APR. Day 20 Year 1968		2b. HOUR 2 P.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JAN. 26, 1874		6. AGE (In years last birthday) 94 YRS.
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARTFORD	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BREVIN NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER	12b. KIND OF BUSINESS OR INDUSTRY RETIRED
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY CECIL	13c. CITY OR TOWN PERRY POINT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER _____
14. FATHER'S NAME First Middle Last JOHN HENRY YOUNG		15. MOTHER'S MAIDEN NAME First Middle Last HENRIETTA COFFMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 476-40-7327-A	17. INFORMANT Address Mrs. Arline LAWSON, HAVRE DE GRACE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of rectum 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 154X Anemia				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1966 , to April 19, 1968 , that (I) (we) last saw the deceased alive on 4/20 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE John P. Yun		22c. DATE SIGNED 4/20/68		
22d. PHYSICIAN'S NAME (Type) JOHN P. YUN		22e. ADDRESS Havre de Grace, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APR. 25, 1968	23c. NAME OF CEMETERY OR CREMATORY EPPING CEM.	23d. LOCATION (City or Town) (County) (State) EPPING, WILLIAMS CO. NO. DAK.	
24. FUNERAL DIRECTOR R. Madison Nichols, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE James J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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